S. HRG. 104–384

MEDICAID REFORM: QUALITY OF CARE IN NURSING HOMES AT RISK

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

WASHINGTON, DC

OCTOBER 26, 1995

Serial No. 104–7

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
21–092 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052450-4

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HEARING ON MEDICAID REFORM: QUALITY OF CARE IN NURSING HOMES AT RISK

WEDNESDAY, OCTOBER 26, 1995

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m. in room 628, Senate Dirksen Building, Hon. William S. Cohen (Chairman of the Committee) presiding.

Present: Senators Cohen, Pryor, Burns, Feingold, and Reid.

Staff present: Mary Berry Gerwin, Staff Director; Priscilla Hanley, Professional Staff; Victoria Blatter, Professional Staff; Sally Ehrenfried, Chief Clerk; Elizabeth Watson, System Administrator; Lindsey Ledwin, Staff Assistant; Theresa Forster, Minority Staff Director; Theresa Sachs, Professional Staff

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. The Committee will come to order.

This morning the Senate Special Committee on Aging is examining one of the issues of critical concern to this committee—namely, the need for strong Federal quality of care standards in nursing homes. Today we are going to examine the importance of keeping Federal nursing home standards in place as we move to reform the Medicaid program.

Placing a parent, spouse, disabled child, or other loved one in a nursing home is one of the most agonizing decisions that any family ever faces, and even once we come to peace with that decision, there is the nagging fear that a loved one may not receive adequate care, or may be abused or neglected in a nursing home. That fear continues to haunt families nationwide.

Over two decades ago, family members came before this Committee to reveal their worst nightmares had come true—relatives in nursing homes lying in soiled bed clothes with flies swirling about, tied to bed, or wheelchairs against their will, overdrugged or suffering from severe neglect, at times resulting in death. Staffing at nursing homes was often untrained, unqualified or inadequate, and the nursing homes themselves were often fire traps or safety code violators. In short, some nursing homes were simply warehouses for the dying.

Ultimately, these shocking revelations did not fall on deaf ears. Major coalitions of consumer groups, families, grass root advocates, and the nursing home industry itself worked with Congress on a bipartisan basis to begin the slow march toward preserving and

protecting the rights of nursing home residents and achieving nursing home reform.

Shortly after the Institute of Medicine issued its landmark blueprint for Federal nursing home reforms, the Congress enacted the Nursing Home Reform Act of 1987, the so-called "OBRA 87" requirements for nursing homes receiving Medicare or Medicaid payments.

The basis for this Federal law was simple, strong, and very clear—that residents in nursing homes which receive Federal Medicare or Medicaid dollars should be treated with care and with dignity. The law provides a framework through which facilities can help each resident reach his or her highest practicable physical, mental, and general well-being. It also provides critical oversight and enforcement of nursing home standards, following years of evidence that the States simply did not make enforcement of nursing home standards a high priority.

We have witnessed dramatic improvements since 1987. There has been a sharp decline in the use of physical restraints to tie up residents, dropping from 40 percent to 22 percent between 1992 and 1994. Substantial progress has also been made in reducing the inappropriate use of antipsychotic drugs or so-called "chemical restraints" that had been widely used to plunge residents into stupors or disorientation in order to make them more manageable.

We have come a long way, but we are not there yet. Recent inspections of nursing homes reveal that deficiencies ranging from substandard care to conditions posing immediate harm to residents still exist in many nursing homes nationwide.

According to the data from the Health Care Financing Administration, 73 percent of the 2520 facilities surveyed as of September were initially found to be out of compliance. Since July, 3 percent of the facilities surveyed were found to pose immediate jeopardy to the residents or have chronic problems, while almost 20 percent of those facilities were found to have substandard care.

A sample of the cases from these surveys provide a glimpse of the real lives behind these statistics:

In a Florida nursing home a resident was sexually assaulted by a nurse's aide. That same aide had attempted to assault another resident and 10 other residents in the same facility had bruises and skin tears from rough treatment received from nursing assistants.

In Ohio a resident died after being strangled by a vest-type restraint that was applied incorrectly and without doctor's orders.

In Indiana, a resident was found with maggots in wounds, despite earlier citations to the facility to improve care.

It is folly to believe that we will ever totally eliminate poor care from each and every nursing home nationwide. We are, however, at a critical crossroads at achieving our goal of patient protection. Federal standards, oversight, and enforcement of the nursing home reforms are now just beginning to bring national uniformity and consistency in nursing home standards of care. Even more importantly, the Federal law is just beginning to be effective in bringing facilities to task for their poor performance through stiff fines and penalties.

Today's hearing is going to examine proposals which I believe threaten to turn back the clock on the progress that we have made through years and years of struggle. The Medicaid reform proposals passed by the House and now being debated on the Senate floor would repeal the Nursing Home Reform Act of 1987, and in its place States would be required to establish their own standards of care for nursing homes as a condition of receiving Medicaid dollars. While the types of standards the States must develop are loosely based on the principles of the Nursing Home Reform Act, key elements of Federal oversight, enforcement, and national uniform standards are lost under the block grant proposals passed by the House and now being debated by the Senate.

Now, some will attack these proposals on a partisan basis, arguing that Republicans lack compassion and want to turn back the clock on progress that has been made toward improvement. I do not subscribe to that conspiracy theory, and I hope today's hearing will not be used to further this idea.

There is some justification for loosening some of the strings that have been too tightly bound for States in how they apply and spend their Medicaid monies. The Medicaid program has failed to provide States with sufficient incentives to encourage innovative and cost-effective health care and long-term care. In choosing which strings to cut, however, we have to be guided by the stark reality of the last two decades or more. States, while not intentionally callous, have historically given enforcement of nursing home protections very low priority and have failed to enforce and promote patient protections and adequate care.

Eliminating Federal standards, oversight, and enforcement will return us to the days of a patchwork of 50 different sets of State standards for nursing homes with little uniformity or consistency. This will pose particular concerns for our increasingly mobile society when grown children have to choose and monitor nursing home care for their parents from a distance and often from clear across the country.

Like every program, the current Federal regulations of nursing homes is not perfect, and there is room for change. I have concerns, for example, with some specific requirements of OBRA 87 and believe that we have to continue to review how the program is working in practice to determine whether the appropriate balance has been struck in the enforcement provisions of the law.

These flaws in the law, however, should not be used as ammunition to undermine the valuable progress we have made toward assuring quality of care in nursing homes. Our decisions on this issue are going to touch the lives of virtually every American family. Today nearly two million Americans live in nursing homes. These issues will become even more important as we witness the explosion of our aging population in the next century. Our aging population will double in the next 25 years.

Finally, this issue is of vital importance to millions of American taxpayers. Taxpayer dollars account for well over half of the money flowing into nursing homes, so as a major purchaser of these services, the Federal Government should have some say in the level of care it is buying for the elderly and disabled Americans. As we will hear today, there is evidence that shows that good nursing home

care can save money and does save money for the taxpayers by reducing the need for costly hospitalizations brought about by neglect or other poor practices in nursing homes. And to the Governors who have insisted that there should be no strings attached to any kind of Medicaid block proposal—block funding proposals—let me just point out that we intend to spend roughly $800 billion in the next 7 years, which is a sufficient Federal connection that would warrant insisting upon Federal standards and enforcement.

In 1973 I introduced the Nursing Home Patients Bill of Rights as one of the first pieces of legislation that I authored while serving in the House of Representatives—it was in December 1973. The need for strong workable, uniform Federal protections for nursing home residents is just as necessary today as it was then, and we have come too far in this struggle to protect the dignity and physical well-being of the frail and disabled to turn back now.

Finally, I want to pay special tribute to Senator Pryor, who is the Ranking Member and former Chairman of the Aging Committee, for his tireless, personal commitment to this issue. Nursing home patients' rights is an issue that has been very dear to his heart throughout his service in the House of Representatives and in the Senate, and many of the reforms that we now have were developed under his watch through this Committee, and I once again look forward to working very closely with him to make sure that we preserve and refine the Federal protection that he and others have worked so hard to establish.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

This morning the Senate Special Committee on Aging is examining an issue of critical concern to this committee, namely, the need for strong Federal quality of care standards in nursing homes. Today we will examine the importance of keeping Federal nursing home standards in place as we move to reform the Medicaid program.

Placing a parent, spouse, disabled child, or other loved one in a nursing home is one of the most agonizing decisions a family ever faces. Even once at peace with that decision, the nagging fear that a loved one may not receive adequate care, or may be abused or neglected in a nursing home, continues to haunt families nationwide.

Over two decades ago, family members came before this Committee to reveal that their worst nightmares had come true: relatives in nursing homes lying in soiled bed clothes with flies swirling around, tied to beds or wheelchairs against their will, overdrugged, or suffering from severe neglect, at times resulting in death. Staffing in nursing homes was often untrained, unqualified, or inadequate, and the nursing homes themselves were often fire traps or safety code violators.

In short, some nursing homes were simply warehouses for the dying.

Ultimately, these shocking revelations did not fall on deaf ears. Major coalitions of consumer groups, families, grass roots advocates, and the nursing home industry worked with Congress on a bipartisan basis to begin slow march toward preserving and protecting the rights of nursing home residents and achieving nursing home reform.

Shortly after the Institute of Medicine issued its landmark blueprint for Federal nursing home reforms, the Congress enacted the Nursing Home Reform Act of 1987, or the so-called "OBRA 87" requirements for nursing homes receiving Medicare or Medicaid payments.

The basis for this Federal law was simple, strong, and clear: that residents in nursing homes which receive Federal Medicare or Medicaid dollars should be treated with care and dignity. The law provides a framework through which facilities can help each resident reach his or her highest practicable physical, mental, and general well-being. It also provides critical oversight and enforcement of nursing home standards, following years of evidence that the States simply did not make enforcement of nursing home standards a high priority.

We have witnessed dramatic improvements since 1987. There has been a sharp decline in the use of physical restraints to tie up residents, dropping from 40 percent to 22 percent between 1992 and 1994. Substantial progress has also been made in reducing the inappropriate use of antipsychotic drugs, or so-called "chemical restraints", that had been widely used to plunge residents into stupors or disorientation to make them more manageable.

We've come a long way, but we are not there yet. Recent inspections of nursing homes reveal that deficiencies, ranging from substantial care to conditions posing immediate harm to residents, still exist in many nursing homes nationwide.

According to data from the Health Care Financing Administration, 73 percent of the 2520 facilities surveyed as of September were initially found out of compliance. Since July, 3 percent of the facilities surveyed were found to pose immediate jeopardy to residents or have chronic problems, while almost 20 percent of the facilities were found to have substandard care.

A sample of cases from these surveys provide a glimpse of the real lives behind these statistics:

- In a Florida nursing home, a resident was sexually assaulted by a nurse's aide. The same aide had attempted to assault another resident, and 10 other residents in the same facility had bruises and skin tears from rough treatment received from nursing assistants.
- In Ohio, a resident died after being strangled by a vest-type restraint that was applied incorrectly and without doctor's orders.
- In Indiana, a resident was found with maggots in wounds, despite earlier citations to the facility to improve care.

It is folly to believe that we will ever totally eliminate poor care from each and every nursing home nationwide. We are, however, at a critical crossroads at achieving our goal of patient protection. Federal standards, oversight, and enforcement of the nursing home reforms are now just beginning to bring national uniformity and consistency in nursing home standards of care. Even more importantly, the Federal law is just beginning to be effective in bringing facilities to task for their poor performance through stiff fines and penalties.

Today's hearing will examine proposals which I believe will threaten to turn back the clock on the progress we have made through years of struggle. The Medicaid reform proposals passed by the House and now being debated on the Senate floor would repeal the Nursing Home Reform Act of 1987.

In its place, States would be required to establish their own standards of care for nursing homes as a condition of receiving Medicaid dollars. While the types of standards the States must develop are loosely based on the principles of the Nursing Home Reform Act, the key elements of Federal oversight, enforcement, and national uniform standards are lost under the block grant proposals passed by the House and being debated by the Senate.

Some will attack these proposals on a partisan basis, arguing that Republicans lack compassion and want to turn back the clock on the progress that has been made toward improving the quality of care in nursing homes.

There is, in fact, justification for loosening some of the strings that have too tightly bound States in how they spend their Medicaid moneys. The Medicaid program has failed to provide States with sufficient incentives to encourage innovative, cost-effective health care and long-term care.

In choosing which strings to cut, however, we must be guided by the stark reality of the last two decades. States, while not intentionally callous, have historically given enforcement of nursing home protections very low priority and have failed to enforce and promote patient protections and adequate care.

Eliminating Federal standards, oversight, and enforcement will return us to the days of a patchwork of 50 different sets of State standards for nursing homes, with little uniformity or consistency. This will pose particular concerns for our increasingly mobile society, when grown children have to choose and monitor nursing home care for their parents from a distance—often clear across the country.

Like every program, the current Federal regulation of nursing homes is not perfect, and there is room for change. I have concerns, for example, with some specific requirements of OBRA 87 and believe that we must continue to review how the program is working in practice to determine whether the appropriate balance has been struck in the enforcement provisions of the law.

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come even more important as we witness the explosion of our aging population into the next century.

Finally, this issue is of vital importance to millions of American taxpayers. Taxpayer dollars account for well over half the money flowing into nursing homes, so as a major purchaser of these services, the Federal Government should have some say in the level of care it is buying for elderly and disabled Americans. As we will hear today, evidence shows that good nursing home care can save money for taxpayers, by reducing the need for costly hospitalization brought about by neglect or other poor practices in nursing homes.

In 1973 I introduced the Nursing Home Bill of Rights as one of the first pieces of legislation I authored while serving in the Houses of Representatives. The need for strong, workable, uniform Federal protections for nursing home residents is just as necessary today as it was then. We have come too far in our struggle to protect the dignity and physical well-being of the frail and disabled to turn back now.

Finally, I want to pay a special tribute to Senator Pryor, the Ranking Member and former Chairman of the Aging Committee, for his tireless, personal commitment to this issue. Nursing home patients rights is an issue that has been very dear to his heart throughout his service in the House of Representatives and the Senate. Many of the reforms we now have were developed under his watch through this Committee, and once again I look forward to working closely with him to preserve and refine these Federal protections.

Senator Pryor.

STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Mr. Chairman, I want to thank you and personally commend you not only for holding this most timely hearing this morning of the Senate Special Committee on Aging on the issue of nursing home standards, but I want to thank you also for your long-term involvement in, and commitment to this issue. I think this is a very non-partisan—or, I should say, bipartisan committee—but I know sometimes it must take a great deal of courage for you almost as the singular member of your political party to come out in favor of the restoration of these very basic minimum standards to help protect the two million American nursing home patients that we have now. I want to thank you for that courage and that commitment, and I look forward to working with you in the next several hours of the reconciliation debate to see if we might not do something actually worthy to be remembered and worthy of our effort that we have shared here together.

Mr. Chairman, colleagues, and members of the Committee, I just want to hold up—I know this has been done a lot in the last few days—this 2,000 page bill that we are now considering. For some of our guests who have just gotten into Washington for this hearing, this is the so-called Reconciliation Bill, the budget bill. Everything that you imagine and then can't even imagine is in this particular legislation. I was asked by a member of the press last evening if I had read the Reconciliation Bill, and I must say I have not. I hope some of my colleagues have, but I doubt that they have.

Senator REID. You haven't read it?

Senator PRYOR. I have not read it, Senator Reid, but I'm hoping to before we start voting on some amendments, if we ever get to them. [Laughter.]

Senator REID. It's at noon.

Senator PRYOR. It's at noon. I hope to read it by noon.

Well, there is one thing absent from this Reconciliation Bill of 2,000 pages. There is a complete void of any protections whatsoever for the nursing home patient in America. You can look through every section, every comma, every paragraph, every part of this

2,000 page bill and you will find nothing that protects the nursing home patient. We protect bald eagles, polar bears, prison inmates, dogs, cats, endangered species, spotted owls and everything, but yet we are walking away from the basic protection and the duty and responsibility that we have to protect nursing home patients. We have two million such nursing home residents. In just a very few years we are going to have over four million. As Senator Cohen said, we are going to double that population.

Well, how did we get from that point to this point? What has happened in the meantime is basically pretty simple. We saw in 1987 as Senator Cohen has mentioned, in the budget reconciliation act, Congress for the first time saying, we must have Federal standards for the nursing home resident. It was a bipartisan effort. I remember well the late Senator John Heinz of Pennsylvania. Senator Heinz took this on as one of his goals. I remember well Senator Cohen's former colleague and our former colleague from Maine, Senator George Mitchell. Senator Mitchell took this on as one of his strongest commitments in the legislative field. All of us worked together, Republicans and Democrats, conservatives and liberals, to make certain that the nursing home patient was going to have some very, very basic protections.

Well, we passed that in 1987. The protections were signed into law by a Republican President. We actually implemented the laws starting about 2 years after that, and for the past several years we have seen dramatic changes in what has happened in American nursing homes, dramatic changes. I will show you in just a moment on some of these charts, but now we are trying to take away the very basic protections that these individual residents have.

You know, they are not really all that complicated. The regulations, or standards, as I call them, are about the freedom and privacy to open your own mail, the freedom and privacy to make certain that no one gets hold of your medical records in a nursing home, the freedom to make certain that you are not overdrugged, the freedom to make certain that you can't be kicked out of that nursing home in the middle of the night and sent out on the street or sent to another nursing home of inferior quality—these are basic fundamental rights that we are about to see taken away from the nursing home residents if we are not very careful.

On September 29 I offered an amendment in the Senate Committee on Finance to restore these very basic rights. By a vote of 10 to 10—and I needed 11 votes, I might say—on a 10 to 10 tie I was voted down. The amendment failed, but I want to thank sincerely from the bottom of my heart another courageous Senator, Senator John Chafee of Rhode Island, who voted with us to restore these very basic nursing home standards.

I so hope in the next few hours as we go into the voting process of the Reconciliation Bill that we will hold hands across the aisles, Democrats and Republicans, and return to our common sense and hopefully a sense of decency and purpose and restore these nursing home regulations.

Time Magazine just this week had a wonderful article—I urge you to read it—about what is going to happen if we don't have any nursing home standards in our country, and basically their bottom line after a lot of study indicates that some of the shoddy nursing

homes are going to get worse, and it will bring shame and disgrace upon the entire nursing home industry.

Ironically, the nursing home industry is not here lobbying to have these regulations repealed—that's the irony of this. I am not sure what is motivating it. One of our colleagues on the Finance Committee said it is part of a new philosophy of government. Well, the reason the Federal Government had to step in 1987, as all of my colleagues know, and enact OBRA 87 and have nursing home regulations is the States—in all due respect and I'm a former Governor—the States were not capable nor did they have, as we saw it, the commitment to have these nursing home regulations in their particular laws and regulations on the State level.

I would like to look at some of the characteristics of the nursing home patients just for a moment. Seventy-seven percent need help with dressing, 63 percent need help in toileting, 91 percent need help in bathing, and 66 percent that have some mental disorder. Another amazing figure that is not on the chart is the fact that some 75 percent of all the nursing home patients in our country today have no relative or no friend that checks on them on a regular basis, and they have no advocate to speak up for their rights. We have seen that the regulations have helped in decreasing the number of days of hospitalization—and you can go to the next chart. I won't go through these because I have taken far too much time. We have seen the decreases in problem areas, dramatic decreases, since these regulations were in fact in place—the next chart please.

Finally, let me just say that this is the projected growth that Senator Cohen and I have talked about: 1.9 million people today, 4.3 million people just a few years from now. Most of the people in fact in this room are going to be in that 4.3 million figure. Now the question is, are we going to be humans or are we going to be statistics? I think I know what the answer should be. I also think I know what the answer should be if the nursing home residents of America today could vote on whether to restore these very basic protections or not. We know what that vote would be.

Mr. Chairman, again, I thank you and I apologize for taking so much time, and I yield at this time.

The CHAIRMAN. Thank you, Senator Pryor.

Senator Burns.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you very much, Mr. Chairman. Oh, you're still there. We will get the iron works down here in a little while, but we will start working through the mass here. [Laughter.]

Thanks for holding this hearing. I want to just bring up one point, I guess, this morning, as we're looking forward to hearing and reading the testimony today, which I want to. But I want to just say to my colleagues how many of you have held county office? Were you a county commissioner? Were you a county commissioner? Well, were you a county commissioner where you had under your management a county nursing home?

Well, I was and let me tell you, Senator Pryor, don't throw Montana in with some of these States that don't have advocates for people who are in nursing homes and the quality of care that's there

because I know that doesn't always exist and was not in Yellowstone County, Montana. So what we're talking about—and I think what we're talking about here is very important and I'm one who has always believed in State and local levels of control and the decisions are made better and more quickly at the local level. However, in Federal programs I will have to admit—which Medicaid and Medicare still are—I think there needs to be some Federal oversight responsibilities. There has to be, and I know I've heard from some of our nursing homes in Montana that the concerns that we are block granting funding to the States to give them control and flexibility. Yet, OBRA regulations still apply and the paperwork demands will continue.

This is a legitimate concern, I think, on the parts of nursing homes, and I look forward to hearing of experiences here first-hand from our panel. I'm sure you feel that OBRA is essential to maintaining the quality assurance in nursing homes, and no doubt in your cases that's true, but perhaps with the changes that we're making in the entire system we can hold onto the comprehensive standards, streamline the paperwork and minimize the paperwork burden on the staff.

Quality assurance is essential, but taking staff away from nursing home residents to do paperwork is not just poor care, it is no care. We have got to allow nurses, nurses aides, and physicians to get back to patient care, and this is one thing that I noticed when I was commissioner in Yellowstone County, Montana. We actually had an incident in Broadus, Montana, recently where three nurses resigned due to the frustration of paperwork and over-regulations, and that should never happen. Three resigned—now Broadus, Montana, is a little bitsy town in Powder River County down on the Tongue River that absolutely we cannot afford to lose those kinds of people in rural areas. You've got to remember that I don't come from the State of Arkansas. I come from a State where there is a lot of dirt between light bulbs, and it's hard to maintain quality personnel in those areas, and I have faith in Montana. In fact, I have read of fraud in Medicare and Medicaid, and we're trying to do something about that, and I will say this—in the State of Montana we are not exempt from fraud and abuse, but I will tell you this—we have so few incidents in the State of Montana the Inspector General of the Department of Health and Human Services does not have anyone working cases in Montana. So we take very serious this business of maintaining quality health care and nursing home care for our elderly in the State, and I would hope that every State has that kind of commitment because we have had great leadership on that and I appreciate that.

So I appreciate this hearing. I think it's timely. We are discussing these things and I would have to go with my good friend from Arkansas—this is a non-partisan thing, this is a human thing, and he is exactly right. Sometimes we have all kinds of laws protecting the Grizzly Bear, which if you have ever seen one, they don't need a lot of protection. Yet, we still don't have the commitment from public elected officials to make sure that nursing homes operate in a humane way and in a way that serves the people.

So I thank you for having this hearing. Thank you very much.

[The prepared statement of Senator Burns follows:]

REMARKS BY SENATOR CONRAD BURNS

Mr. Chairman, I thank you for holding this hearing today. What a timely subject. As the Senate is focusing on ways to reform Medicaid and Medicare, it is important that we keep in mind the protections already in place that assure quality health care for those in nursing homes.

As someone who has always believed that the local and State levels can make much better decisions and more quickly, I do favor local control. However, in the case of Federal programs—which Medicare and Medicaid still are—I think there needs to be some Federal oversight or guidelines.

I know I've heard from some of our nursing homes in Montana and they are concerned that we are block granting funding to the States, to give them control and flexibility and yet, the OBRA regulations still apply and the paperwork demands will continue. This is a legitimate concern.

I look forward to hearing experiences of our first panel. I am sure you feel that OBRA is essential to maintaining quality assurance in nursing homes and no doubt, in your cases, that's true. But perhaps, with changes that we are making in the entire system, we can hold onto the comprehensive standards but streamline the paperwork and minimize the paperwork burden on the staff. Quality assurance is essential, but taking staff away from the nursing home resident to do paperwork is not just poor care, it's no care. We've got to allow the nurses, nurses aides, and physicians to get back to patient care.

We actually had an instance in Broadus, Montana, recently, where three nurses resigned due to frustration with paperwork and regulations. That should never happen.

I have faith that the folks in Montana would maintain the highest quality health care but I am just as convinced that this would not be the case in other States. I have heard time after time about fraud and abuse in Medicare in other States. I have heard about poor or sometimes abusive care in nursing homes in other States. I am sure that Montana exempt, but we have so few incidences that the Inspector General of the Department of Health and Human Services does not have anyone working cases in Montana. The need does not justify the costs.

I will be paying close attention to the testimony here today. The folks who have stories to tell about their loved ones, the witnesses who deal with OBRA enforcement on a regular basis, and the people who run the nursing homes these regulations apply to—your input and the time you have taken to join us today are very valuable. I hope you can shed some light on the whole issue of whether OBRA 87 is a necessity or whether we can make some changes to reduce the burden on the nursing homes while maintaining the integrity of the health care delivered. I would think that there is a common ground in there that would serve the patients well and alleviate the burden the care givers are feeling.

Mr. Chairman, you are once again on the forefront of issues that affect our seniors and I appreciate your commitment to finding solutions to improve and protect our health care system. Thank you.

The CHAIRMAN. Thank you, Senator Burns.

STATEMENT OF SENATOR RUSS FEINGOLD

Senator FEINGOLD. Thank you, Mr. Chairman.

We are in one of these typical Senate situations a three-ring circus where I'm supposed to be at a judiciary vote and I'm supposed to be speaking on the floor on Medicaid, but I am very impressed that the Chair would call this hearing. I have to leave briefly but I want to just say a couple of words. I ask unanimous consent that my full statement be placed in the record.

The CHAIRMAN. Senator Feingold, if it will give you any comfort, I'm supposed to be at the meeting at the Majority Leader's Office right now discussing this matter.

Senator PRYOR. We will get into repent on this nursing home standard issue. [Laughter.]

Senator FEINGOLD. Well, I'm very glad you have done this. I have to give you tremendous credit, given the fact that there is a tremendous effort on the part of the majority to pass the reconcili-

ation package. Of course, I agree with the ranking member's statements that this is a terribly serious matter.

Although, Senator Burns, I did not serve as a county official, I was chairman of Wisconsin's Aging Committee for 10 years, I have served 13 years in a row as a member of Aging Committees and have visited perhaps more nursing homes and homes in community-based facilities—perhaps—than any member of the Senate. All I can say is that these regulations in 1987 made a tremendous difference in Wisconsin. They gave people the ability to challenge abuses. Without them, we will have a problem. It is not so much the case that our State government doesn't want to do something about it—we have a very good State government in this regard—the problem is that the good actors may be at a competitive disadvantage to bad actors, nursing home operators who don't, perhaps, care enough about providing the protections that current Federal laws require.

I want to say one other thing—I do believe, having been a State Senator for 10 years, that many matters are best handled by the States. I have voted this year already to leave it up to the States to decide about the speed limit, the drinking age, and to decide if we're going to have helmet laws. I have voted for all of that. But some areas require Federal action. For example, we cannot solve air pollution at the State level, but there are people around here that are saying that, and the same goes for nursing home regulations, I'm afraid. If you do not have basic, national regulations, the quality of care in nursing homes will go down and it would be an extreme offense to so many individuals who are elderly and their families if we don't change this. I'm going to leave it at that. I believe it would be very difficult for anyone to vote for this recollection package if this isn't removed.

I thank the Chair.

[The prepared statement of Senator Feingold follows along with prepared statements of Senator Craig, Jeffords, and Kohl:]

PREPARED STATEMENT OF SENATOR RUSS FEINGOLD

Mr. Chairman, I commend you and our Ranking Member, Senator Pryor, for convening the Committee on this extremely timely issue. And I especially want to congratulate you for no small amount of political courage in calling this important hearing.

I know there must be tremendous pressures for members of the majority party to accept the reconciliation product as reported by the Budget Committee without change. That is the nature of political process. Current and future nursing home residents owe you a debt of gratitude for both your leadership on this issue, and for your willingness to rock the boat at a time when I'm sure many of your colleagues would prefer you did not.

Mr. Chairman, I also have to note for those who do not see the value of this Committee that here again we have another dramatic example of the desperate need for a Senate Aging Committee.

It was this very Committee that was in large part responsible for the nursing home regulations that were enacted as part of OBRA 87. And if Federal standards are to be maintained in this area, it will again be because of this Committee.

Mr. Chairman, Wisconsin nursing home residents have clearly benefited from OBRA 87 regulations. They opened the doors of information to residents and their families. They were informed of their rights and given specific information of how to contact their ombudsman.

They also benefited from improved care. Comparing their case activity before and after implementation of the OBRA 87 regulations, staff of Wisconsin's Board on Aging and Long-Term Care found significant improvement in the area of the most

serious problems. Complaints of the worst conditions—"Danger of Death or Severe and Lasting Harm"—dropped as a percentage of all complaints.

They found similar improvements in the areas of resident care and nursing services.

Mr. Chairman, let me stop here. I know time is short, and I very much want to hear today's witnesses.

I will just conclude by thanking you and the Ranking Member again for holding this hearing. It could not be more timely.

PREPARED STATEMENT OF SENATOR LARRY E. CRAIG

Mr. Chairman, this hearing is very timely, as the full Senate considers Medicare and Medicaid reform in budget reconciliation. I know issues of concern have been raised on changes to both the Medicare and Medicaid programs. The effect those changes will have on the quality of care in nursing homes is a critical issue to all of us.

Mr. Chairman, the comments you made during debate on budget reconciliation yesterday on this issue were very important. They are important because they serve to inspire the kind of debate we need to have today. However, that debate will not begin or end in this hearing. It will, and should, be continued beyond the actions taken in budget reconciliation. Mr. Chairman, this is the kind of debate that will help direct us on how to ensure that standards of quality are not a stagnant issue. Standards of quality, whether they are established and enforced by the States or by the Federal Government, are an issue that will require the Congress' continual oversight.

Therefore, Mr. Chairman, your commitment to ensure that the vulnerable people who reside in nursing homes are protected, is appreciated. In addition, I would just say that, coming from a State with many rural or frontier areas, the commitment to quality requires a delicate balance so that regulations and bureaucracy do not become barriers of access to nursing home care.

Mr. Chairman, this happens to be an issue that I have also been working on with my home State, Idaho. Our State's Governor and Department of Health and Welfare have been working not only on the new enforcement regulations being implemented by the health care financing administration, but our State had also developed State level enforcement policies as well. That is important to note, because the Medicaid Reform Proposal included in budget reconciliation includes changes to OBRA 87, shifting responsibility for nursing home standards of quality back to the States.

As you know, under this proposal each State will establish and maintain standards for maintaining quality of care in nursing homes. The State plans must include the following:

Treatment of resident medical records;
Policies, procedures and bylaws for operation;
Quality assurance systems;
Resident assessment procedures, including care planning and outcome evaluation;
Safety and adequacy of the physical plant;
Qualifications for staff of facilities;
Utilization review;
and, the protection and enforcement of resident's rights.

In addition, the States will have to establish and operate a program for the certification and decertification of nursing homes. Under that program, States will be required to ensure that the public has access to the results of surveys and evaluations of nursing homes. States would also be responsible for establishing procedures for sanctioning nursing homes with deficiencies, and procedures for terminating the participation of nursing homes that jeopardize the health and safety of its residents.

Mr. Chairman, I do have confidence in the State of Idaho's ability to deal with the issue of nursing home quality standards. On many of these kinds of issues, I have supported the States' involvement over the Federal Government, because State governments are so much closer to the people. The ability of States to act and react to problems is much more flexible. Therefore, I do feel that they have the ability to work from the level of national standards that have been established under OBRA 87. In addition, they may also be in a better position to control the enforcement of standards, because they can react more quickly when problems or inadequacies in the system are rooted out.

Having said that, if this transition of authority to the State is going to be successful, the Congress will need to "guarantee" it by maintaining its oversight responsibilities. The testimony we will hear today will be helpful in looking at both posi-

tive and negative aspects of this proposal. I look forward to the benefit of the insight of today's witnesses.

PREPARED STATEMENT OF SENATOR JIM JEFFORDS

I would like to commend Chairman Cohen, for convening this timely and very important hearing on nursing home standards as Medicaid reform is being debated on the floor of the Senate.

The Declaration of Independence and the Constitution outline basic and unalienable rights. No where in those documents does it state that when you become disabled or infirmed, you forfeit these rights. But, prior to 1987 that is exactly what was occurring to many elderly and disabled who were in nursing homes. Some Americans, living in nursing homes, suffered from poor quality of care, poor quality of life, and abuse.

In 1987, we in Congress, revised Medicare and Medicaid by placing requirements on nursing homes that received Federal compensation. We did this because of compelling evidence of poor care and abuse, such as that documented in the 1986 Institute of Medicine Study, *Improving the Quality of Care in Nursing Homes.* The Federal nursing home standards that were introduced as a result included: (1) freedom from abuse, punishments and restraints; (2) privacy; (3) accommodation of individual needs; (4) voicing grievances; (5) participating in social, religious and community activities.

These are basic human rights that must be guaranteed. Prior to OBRA 1987, 40 percent of residents in nursing homes were in restraints. Today less than 20 percent are in restraints. Progress has been made but still more needs to be achieved. Some of the witnesses today will tell us about personal and disturbing examples of nursing home abuse and neglect. Nursing home representatives will tell us of the impact of current standards on today and tomorrow. We need to listen and then insure that our actions protect residents and allow nursing homes the appropriate tools to meet these needs.

Today, as we consider block granting Medicaid, authority to regulate nursing homes could be turned over to the States. While it is important that we allow States the ability to design programs that meet the needs of their citizens, we must also keep in mind, that the Medicaid program is a partnership between the Federal and State Governments to help the most vulnerable people in our society—the poor, aged and disabled.

We must assure that the protections afforded nursing home residents, by the passage of OBRA 1987, and the progress made in providing quality care in nursing homes, is maintained. It is critical that we retain Federal standards for nursing home facilities, to insure all people of this country, that they can maintain their dignity in which ever nursing home they may choose to reside.

Mr. Chairman, I look forward to hearing the testimony of the outstanding panels of witnesses you have invited to today's hearing.

PREPARED STATEMENT OF SENATOR HERB KOHL

Mr. Chairman, thank you for holding this hearing. The Senate is on the eve of voting on a budget bill that includes an outright repeal of the Nursing Home Reform Act (OBRA 1987). In lieu of the national standards, States would be allowed to set their own criteria, just as they were able prior to 1987.

Mr. Chairman, I hope it's not too late for our review of the positive results that the Nursing Home Reform Act has had on the quality of life of elderly and frail Americans confined to nursing homes. In doing so, the Senate may make an informed decision on whether to repeal or work on ways to refine the standards.

These standards have benefited thousands of elderly people across the Nation. Before implementation, there were widespread instances of neglect, whether intentional or not, that left nursing home residents in poor health or even worse.

The national nursing home standards are intended to give nursing home residents as much freedom over their lives as possible. People in nursing homes are there because they lack the ability to live on their own. These standards recognize that uniform protections must be provided to the elderly who are confined to nursing homes and give them some modicum of self-determination.

Why was this Federal law necessary? After exhaustive studies, it was determined that seniors were being unnecessarily drugged, restrained and otherwise mistreated against their will. States either had inefficient laws on the books or were negligent in enforcing protections.

So, legislation was passed in 1987, with broad bipartisan support setting uniform national standards. This law directed nursing facilities to maintain basic civil rights of residents, while focusing on quality of care and quality of life.

In the process, many nursing home administrators feel that too much paperwork was created. They may be right. They may also be right that better guidance can be provided before the most severe sanctions are levied. But the final provisions of the law, those dealing with enforcement, have only been in effect since July of this year. Clearly, the Senate should not overturn this law that has helped so many, without a comprehensive review of its impact and to explore possible refinements.

Time and money spent on unnecessary paperwork could be more appropriately used to provide quality care. But relief from paperwork does not justify eviscerating uniform standards relied upon by nursing home residents and their families.

Mr. Chairman, I welcome this hearing and look forward to testimony from the panels.

The CHAIRMAN. Thank you, Senator Feingold.

Senator Reid.

STATEMENT OF SENATOR HARRY REID

Senator REID. Mr. Chairman, I, like the others, appreciate not only the hearing but the timeliness of the hearing, and I say to my friend from Arkansas, John Chafee is a man of great courage not only here in the Congress but on the beaches of Southeast Asia during the Second World War and, of course, in the cold hills of Korea during the Korean conflict, and I say this about our chairman:

Senator Pryor, you and I have been on this Aging Committee with Senator Cohen for many years now, and prior to his becoming chairman, has been heavily involved in all the things we've done, and I have no doubt that if Senator Cohen had an opportunity to vote in the Finance Committee, he would have voted with you, and it would not have been a tie.

We also have a conference Appropriations Transportation meeting at 10, and I have to go to that. Mr. Chairman, I have read the transcripts of the proposed testimony and that of Gloria Messerley, Mildred Manning, and Dorothy Garrison is an example of what Senator Pryor indicated. The reason that these people are here telling their story is that they have or did have aged family members or sick family members that they were trying to help. They had relatives, not like the 75 percent approximately that are in these rest homes, these convalescent homes, and so the reason we need national standards is for the 25 percent, as represented in the testimony today but especially for the 75 percent that have no one to speak for them.

We all brag about our States, what great States they are. You have been Governor of your State, Senator Pryor, but we need national standards. We need them in Nevada, we need them in Arkansas and we need them in Maine, and I hope that before we finish this Reconciliation Bill that the provision repealing national standards is taken out of there. There is no one that has called me and said, "Get rid of those standards." We need them and we need them for a lot of reasons.

In the mid-1980's, more than 40 percent of nursing home patients were restrained—that is, strapped to beds. Now it's less than 20 percent. We have made great progress, and so, Mr. Chairman, I appreciate the hearing being held. I think the list of witnesses—I have read all the testimony in panel one, and panel two. I haven't

read panel three's testimony but I will, and, again, I extend my personal, public appreciation to you for the leader that you have been. I didn't think anyone could match Senator Pryor, but you have done a wonderful job leading the Committee, and I appreciate the work that both of you have done as Chair and co-chair of this very important Committee.

The CHAIRMAN. Thank you very much, Senator Reid.

Let me indicate to my colleagues, Senator Pryor, Senator Reid and those who preceded them in comments that I hope that by the time we start voting today that this matter will be resolved. I believe we have heard the name of Senator Chafee mentioned on several occasions here this morning. He truly is an outstanding man of courage, and he, and I and others are working as we speak here this morning to make sure that these standards—and not only the standards but the enforcement aspect of the OBRA 87 is restored. So I hope that before this hearing is even concluded that we will have good news to spread to this audience.

In the meantime, we are going to call our first panel. After listening to the Senators talk, we are going to hear from the people who are directly impacted.

The members of our first panel have all seen family members suffer because of deficient care in nursing homes. The panel includes Dorothy Garrison from Mobile, Alabama, Mildred Manning of New Market, Virginia, and Gloria Messerley of Harrisonburg, Virginia. Mrs. Messerley is accompanied by Anne See of the Blue Ridge Legal Services. All three of the witnesses are going to provide the Committee with first-hand accounts of the abuse that their family members suffered from overmedication to intentional neglect by nursing home staff, and they are going to explain why they believe that Federal standards are necessary to ensure that loved ones are protected.

Let me thank all of you for coming, and, perhaps, Ms. Garrison, would you like to proceed?

Mrs. Garrison.

STATEMENT OF DOROTHY GARRISON, DAUGHTER OF MERLE DAVIS, A FORMER NURSING HOME RESIDENT, MOBILE, AL

Mrs. GARRISON. My name is Dorothy Garrison, and I am from Mobile, Alabama.

Thank you for the opportunity to speak here today. I would like to tell the story of my mother and how she survived not one, but two nursing homes.

In February 1992 my 85-year-old mother was living in Mississippi. She became ill and was admitted to the hospital. When she was ready to be discharged, the doctor didn't want her to live by herself. Mother didn't want to go into a nursing home. My husband and I went to Mississippi and brought her home to live with us. During the month of May, both Mother and my husband was admitted to the hospital. He had to have heart surgery. Mother and I decided that it would be best if she went into a nursing home to get some of her strength back. Mother's admission to that nursing home was on May 29, 1992. We were not told our rights. We did not even know we had any rights. Neither Mother nor I was

asked to attend care plan meetings or to participate in assessments.

When Mother entered the nursing home, she could walk with assistance. She knew when she had to go to the bathroom and she was oriented. The nursing home did not tell us what drugs they planned to give Mother. One of the first drugs that they gave her was Lortab. Had they asked us about the drugs that she could take, they would have found out that she got very confused when she took Lortab and could not take them.

When Mother became confused, she started wandering all around the building. The nurses called the doctor and got orders for drugs to control Mother so that they wouldn't have to take care of her. When those drugs made Mother even more confused, the nurses got orders for even more drugs. They messed with Mother's mind severely and she was treated inhumanly. There were times when she felt that they were trying to kill her. When Mother refused the drugs, they either gave her injections or hid the medicine in her food. When I asked what was happening to Mother's mind, I was told, "All old people act that way."

Because they were so short of staff, there often were not enough people to bring Mother to the bathroom. Mother complained that some of the people who took care of her were rough. She pointed out one CNA and Mother said the CNA pulled her to the bathroom and threatened not to bring her again if she could not walk faster.

They started putting diapers on Mother. She was humiliated. Mother was always a proper lady. The staff restrained my mother. They used restraints without evaluating whether or not she needed them. They restrained her without a doctor's order. Later when my mother was out of that nursing home, she testified that the restraints made her feel like she wasn't even a citizen. The medicines made Mother weak and confused. She was not eating well. Mother began to fall. She fell so hard on cement she had a big knot and a cut on her head. She was covered with blood but they didn't bother to clean her up. They let her sleep in the same dirty clothes that she had on when she fell and she slept on bloody sheets.

Mother had many falls and was often injured. Once her ribs were broken. No one could ever tell me how or when these accidents happened.

On January 26, 1993, Mother fell and injured her eye. This was probably a blessing because Mother was transferred to a hospital where they stopped all psychoactive drugs that she was getting. The doctors thought Mother was very confused when she was first admitted to the hospital. After the drugs were out of her system, they changed their mind.

Mother had to have surgery on her eye but her eyesight could not be saved. They left her eye open so it would make her look a little better. They gave her drops to ease the pain. The drops may not continue to control the pain so then they would have to close her eye.

Mother was admitted to a second nursing home after this hospitalization. The second nursing home gave us a copy of our rights. After I found that our rights had been violated, I contacted a lawyer to file suit against the first nursing home. Later we received some books from the National Citizens Coalition for Nursing Home

Reform. These books explained our rights. We knew more about what nursing homes were supposed to do for the people in them.

They started restraining Mother in the second nursing home, she didn't like it. One day with the help of a friend we told the nursing home that we did not want them to restrain Mother any more. They were not happy but they agreed to it. The Nursing Home Reform law gave my mother and me the right to refuse the use of these restraints.

In October 1993 Mother developed a urinary tract infection. These infections make older persons confused. I asked the nursing home to check it, but they just wanted to use the drugs to make her quiet. Finally, Mother went to the emergency room and they gave her antibiotics and it didn't take long before Mother was herself again.

The nursing home still wanted to use psychoactive drugs, but Mother did not want to take them so I told the nurses, "No." I called my attorney and he sent a letter to the nursing home. He wrote that according to the law they could not force my mother to take medicines that she did not want.

In December 1993 we received a letter from the nursing home saying that because we did not agree to the restraints and the psychoactive drugs that they were going to dismiss my mother from the nursing home. According to the Nursing Home Reform law, we had 30 days to appeal this discharge. Again, we contacted my lawyer and he told us that the nursing home could not discharge my mother for those reasons. His office wrote a letter to the Medicaid Department appealing the discharge. After an investigation, Medicaid wrote back and told us that the nursing home could not discharge Mother. We were happy. Mother wanted to stay in this nursing home until she was able to come home again.

I wish I could say all of our problems were solved. They were not, but we had our rights and the Nursing Home Reform law. My friend helped us and we were able to force the nursing home to give Mother better care. It would have been easier if the State of Alabama had enforced the law so we didn't have to fight so hard.

On June 1995 Mother was strong enough to bring home. In July we visited relatives in Tennessee, Mother can climb stairs, she plays dominos with us, she is her old self again. This September when her case went to trial, the judge interviewed her. He decided that Mother was competent enough to testify. It wasn't necessary because after 2 days of testimony, the nursing home agreed to settle the case.

Before the trial was completed—Congress, do not turn your back on this country's elderly and disabled. Please keep the Nursing Home Reform law in place to protect people like my mother. Without it she would be dead.

[The prepared statement of Ms. Garrison follows:]

PREPARED STATEMENT OF DOROTHY GARRISON

My name is Dorothy Garrison and I am from Mobile, Alabama. Thank you for the opportunity to speak hear today. I would like to tell the story of my mother and how she survived, not one, but two nursing homes.

In February 1992 my eighty-five year old mother was living in Mississippi. She became ill and was admitted to the hospital. When she was ready to be discharged, the doctor did not want her to live by herself. Mother did not want to live in a nurs-

ing home. My husband and I went to Mississippi and brought Mother home with us.

During the month of May, both Mother and my husband were admitted to the hospital. Because my husband had heart surgery Mother and I decided that it would be best if she would go to the nursing home for just a little while to get her strength back. On May 29, 1992, Mother was admitted to the first nursing home.

Mother's admission to that nursing home was our first experience with nursing homes. We were not told our rights. We did not even know that we had any rights. Neither Mother nor I was asked to attend care plan meetings or to participate in assessments.

When Mother entered the nursing home, she could walk with assistance; she knew when she had to go to the bathroom; and she was oriented.

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Because they were so short of staff there often were not enough people to bring Mother to the bathroom. Mother complained that some of the people who took care of her were rough with her. She pointed out one CNA. Mother said the CNA pulled her to the bathroom and threatened not to bring her again if she did not walk faster.

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Later we received some books from the National Citizens' Coalition for Nursing Home Reform. These books explained our rights. We knew more about what nursing homes were supposed to do for the people in them.

They started restraining Mother in the second nursing home. She did not like it. One day, with the help of a friend, we told the nursing home we did not want them to restrain Mother anymore. They were not happy, but eventually they agreed. The Nursing Home Reform Law gave my mother and me the right to refuse the use of restraints.

In October 1993 Mother developed a urinary tract infection. These infections may make older persons confused. I asked the nursing home to check it, but they just wanted to use drugs to make her quiet. Finally Mother went to the emergency room where they ordered antibiotics. Soon Mother was herself again. The nursing home still wanted to use psychoactive drugs.

Mother did not take them so I told the nurses no. I called my attorney and he sent a letter to the nursing home. He wrote that according to the law they could not force my mother to take medicines that she did not want.

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After an investigation Medicaid wrote back and told us that the nursing home could not discharge Mother. We were happy. Mother wanted to stay in this nursing home until she could come home.

I wish I could say all of our problems were solved. They were not, but we had our rights and the Nursing Home Reform Law. My friend and the ombudsman helped us and we were able to force the nursing home to give Mother better care. It would have been easier if the State of Alabama had enforced the law so we didn't have to fight so hard.

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Congress, do not turn your back on this country's elderly and disabled. Please keep the Nursing Home Reform Law in place to protect people like my mother. Without it she would have died.

The CHAIRMAN. Thank you very much, Mrs. Garrison.

Ms. Manning.

STATEMENT OF MILDRED MANNING, WIFE OF DAVID MANNING, VIRGINIA NURSING HOME RESIDENT, NEW MARKET, VA

Ms. MANNING. Good morning, ladies and gentlemen. My name is Mildred Manning, and I'm here to speak about the experience of two nursing homes that I had to deal with. My husband, David Manning, he took sick and he lost his kidneys. He was on dialysis and he was this way for about 7 years, and eventually he got sicker and sicker. I had to get home care and a nurse to come out in the mornings, but in the afternoon it was left up to me to look after him and feed him and whatever. So this particular morning he asked me to lead him to the bathroom, and I didn't know that he had a stroke at that time. So I went in to lead him to the bathroom and he just gave a twirl and went down on the floor. It busted his arm open and the muscles all just fell out.

So I called the rescue squad to take him to the hospital, and I knew then that I could not take care of him myself. So I thought that I could put him in a nursing home where they could give him better care than I could. So he spent his time that he had in the hospital and then he had to be released. So I put him in a nursing home, and he was there and gradually his weight just kept going down. They would not feed him. I would go in there and his tray had never even been opened enough. He just gradually kept losing weight. They wouldn't give him his medicine right, and David knew--he could talk to you just like me or you—and he knew when he had to go to the bathroom, he knew when he was hungry and all this. I went in and he kept asking me for money, and I said, "Well, David, I gave you $20 yesterday." And he said, "Well, I need it." And I said, "Well, what are you doing with this money?" And he said, "I'm giving it to Jerry." I said, "What are you giving it to Jerry for?" He said, "To take me to the bathroom."

So David could not reach the bell to ring and he had a habit of beating upside of the bed to get attention for somebody to take him to the bathroom. Well, this made the staff very upset and they wanted to punish him. So they threatened him and told him, "I'm going to take your radio away." They did take his radio away. I went in the next day and his radio was gone, and I went in and I demanded the radio back. I said, "Please, my husband gave me this for my anniversary. I've got to have it back." The lady told me, she said, "If you can identify it." So she took me to this closet and I looked up there and there was my radio.

They also took his wheelchair and his clothes. He just kept getting thinner and thinner, so I started bringing food from home and wheeling him out back and fed him myself. So this one particular day I went out to feed him and he started crying, and I said, "What's the matter?" And he said, "They're going to put me on the floor tonight. They told me that they were going to put me on the floor." And I said, "Oh, no, they can't do that." And he said, "Yes, they told me they would."

So, sure enough, the next day I went back and they had put him on the floor. This was the doctor's orders to put him on the floor so he wouldn't make this noise for attention to get what he wanted. So he had crawled off his mattress and got underneath the bed, no clothes on, and the cold air conditioner blew air down on his back. So he got pneumonia and they wouldn't call the rescue squad. I had to call them myself to come there and get him and put him back in the hospital.

He was in the hospital and served the time he is allowed, and I knew then that I had to find another one because I wasn't satisfied with this nursing home. So I put him in another nursing home, not knowing that these nursing homes were together and they told me when I registered him in there, they said, "No one that comes in here goes out alive." They told me this, this nursing home did.

So I put him in there and every morning at 11 o'clock I would go in there and he would have no clothes on, no where. He would be in a mess from head to toe. This was at 11 o'clock, and I would go in and ask the nurse, "Please, give me some towels or wash rags." They didn't even want to do that, and we would do our best to try and clean him up. This one particular day I went down and the manager of the nursing home told me, he said—this is at 11—"We're having a barbecue out back and personally I am cooking myself, and you're invited." My husband is laying in here in this mess and no one to clean it up.

So from then on, he was on dialysis which had to be changed every 3 hours, and I personally went and—it's on an IV pole and I took a marking pencil and I marked this bag, and the next day I went back and that same bag was there. It had not been changed.

I brought all this to their attention, and it had not been changed at all. Well, if it isn't changed, he develops an infection. So he got the infection. His doctor called me and told me, he said, "Mrs. Manning, I don't know if you know that David may not pull through this because he has an infection and the dialysis that you have is the changing of the bag or you can put a needle in the shoulder that pulls the blood out, purifies it and puts it back." And they

wanted to do this, and he told me—he said, "What do you think?" I said, "Whatever you think is best."

So they went with the operation, put it back in his shoulder and he said, "I hope you're ready for this because he may not pull through." So 7 o'clock that morning they called me and said, "Mr. Manning had pulled through."

Well, I was so happy. It was 8 o'clock and I got another phone call and they told me that Mr. Manning did not pull through.

So, ladies and gentlemen, I'm going to ask you do you think it's right that we should pay these nursing homes to abuse our loved ones? We should keep the laws of the nursing homes so things like this don't happen to you, or me or anyone else.

Thank you for your time.

[The prepared statement of Mrs. Manning follows:]

PREPARED STATEMENT OF MILDRED MANNING

Good morning ladies and gentleman. My name is Mildred Manning. I am from New Market, Virginia. I am here to tell you my story about the experience I have with two nursing homes.

My husband's name was David. David became real sick. He lost both kidneys. He lived 7 years on dialysis. He gradually became worse and worse.

It got so bad I had home care come in and help me in the morning. A nurse came in to check him everyday. I still cooked and looked after him at the evening. I would feed him his meals.

One evening he asked me to lead him to the bathroom. I did not know he had a stroke. When I helped him from the bed, he just twirled and fell. He cut his arm open. The muscles just hung down. I called the rescue squad. I knew then that I could not take care of him by myself. I thought if I put him in a nursing home they could give him better care than I did.

I admitted him to the nursing home on April 1993. David was 54 years old. When David went in the nursing home he knew everything. He knew when he was hungry. He knew when he had to go to the bathroom. He would ask me to bring my guitar and play for him.

Because there was not enough help the aides were not able to take care of him. I would go in and they would not even have the lid off of this food. He began to lose weight. They got so that they would not feed him. It got so bad that I brought in food from home. I took him out on the back porch to feed him.

They did not like him because he knew when he had to go the bathroom. He would bang on the side rails because he could not use the light. My husband started asking for $20.00 every day. I said, "David, what are you doing with this money. I just gave you $20.00 dollars." He said "I'm giving it to Jerry, he takes me to the bathroom." They started making him wear diapers. He didn't need them if they would have just come and taken him to the bathroom when he banged on the side of the bed. Because David was wearing diapers his butt became blood red. It would ooze blood. I was so worried and concerned that I came home and called the nursing home doctor. He said that he would go and check him next week.

They took David's radio away to punish him for banging on the side rails. I had to go in an demand that they give the radio back. It was a gift from David to me for an anniversary present. Another time they took David's wheelchair away to punish him.

One day when I was on the back porch feeding him, David told me that they were going to put him on the floor. I said, "No honey, there is no way that they would put him on the floor." When I came back the next day I found out that the nursing home doctor had ordered that David's mattress be put on the floor for a punishment.

David could not stay on the mattress. He rolled off the mattress. He went underneath his bed. The air conditioner blew cold air on his back all night. He got pneumonia so they sent him back to the hospital.

After his time ran out at the hospital I had to put him in another nursing home. I did not know that this nursing home was run by the same people. When I admitted David the lady told me that most everyone that goes in the nursing home does not come out alive.

David was getting worse. The dialysis bag was supposed to be changed every 3 hours. My sister and I marked the bag. When we came back the next day we could see that his bag had not been changed one time.

We would find him in a mess, from his head to his toes. He was so cold I went home and got him a blanket. When I came back the next day his blanket and clothes were gone. He didn't even have a diaper on here.

Another day the manager of the nursing home told me that he was having a barbecue. I was invited to the barbecue. He was even going to cook himself. That day while they had a barbecue my husband lay in his mess * * * from his head to his toes.

Now folks, you tell me, do you think that it is right that we pay nursing homes to abuse our loved ones. I know that nothing will help my husband or bring him back. We must keep the Nursing Home Reform Law and we must enforce it so the things that happened to David will not happen to you or me, or anyone else.

Thank you for your time.

The CHAIRMAN. Thank you very much, Mrs. Manning.

Mrs. Messerley.

STATEMENT OF GLORIA MESSERLEY, DAUGHTER OF EDITH BILLER, VIRGINIA NURSING HOME RESIDENT, HARRISONBURG, VA; ACCOMPANIED BY ANNE S. SEE, BLUE RIDGE LEGAL SERVICES

Mrs. MESSERLEY. Good day, thank you for allowing me to speak to you all today. My name is Gloria Messerley. I am from Linville, Virginia, and I am here to tell you a little story about my mom who was in a nursing home. I would like to show you a picture, first of all, of my mom a few years ago.

Mom could walk, talk, and she was just a great mom. She had six kids that she raised. She worked all her life. She would usually have Sunday dinner for all her kids and grandkids. We had a good time. She would like to read her Bible, she would like to go to the senior's center, and she loved to mow her grass. But sometimes after a while mom got kind of forgetful. My sister and I were worried about her so Alice and I said we were going to make her an appointment to go to the doctor because we were afraid that she would take too much medication or not enough. We had it in the day-by-day little holders.

Mom became frightful, frightened at many things and we decided to take her to the hospital. Mom never returned home.

After she got to the hospital the doctor wanted to run some tests. He told us that she had Alzheimer. She stayed in the hospital for 27 days. She went to an adult home for 6 days, and then we found a nursing home. We didn't have long to do this but we had to do it as quick as we could.

The nursing home was owned by a big company. We admitted our mother in this nursing home on October 29, 1993. Mom was furious with us and she said, "I can't believe you're doing this to me," and it made us feel real guilty, OK. When she first went to the nursing home, she could walk, she could talk just like I'm doing right now. She would go to the bathroom by herself, she took pride in keeping herself clean, nice, neat hair, and everything else. She would go play bingo—she liked winning prizes—and she was very nice to everybody.

Mom liked to walk but she didn't get to do it too much at the nursing home unless one of the kids came in and took her. The doctor gave her medicine. This medicine—I'm not a doctor and I can't answer for the doctor—but they gave her medicine that would, like, knock her out all during the morning hours until 2 or 3. She would miss breakfast sometimes lunch, and then, you know, Alzheimer

patients are known for wandering at night any ways. Well, sure, she is going to wander or be up at night. I think we should have gotten this medicine for her in the evening or night to sleep and be awake in the day—things like that.

The medicines were not helping her. The medicines made her very groggy. She started wetting on herself at different times. She started falling around, staggering, and eventually they put diapers on her too. They started restraining her with things like straps—and I have one here that I want to show you. Something like this to tie around your waist or body part. They restrained her in a wheelchair and in the bed. We were dumb enough to ask them to do things like this to keep her from falling, cutting her head and stuff.

Then the sores began. The sores began in, like, July 1994 and eventually it got so bad that they had to send her to the hospital for treatment, and she was there for 9 days to get better. She went to the hospital many times after that. She went for falls, cuts, and she also fractured her hip twice.

On October 19 at 1 o'clock in the morning—my mother's birthday is on the 20th—last year the night before her birthday they called my sister, Alice, and she is in a different town. They had found my mom hanging over the bed, bed railing up, with this tied around her in tact tight as can be. She had already turned blue—I can tell you that—or that what was stated. That day she wasn't the same again. She could not eat right or swallow right, she couldn't drink right, and she could not talk the same. Later they told us that they thought mom had had a stroke. Well, I think if you got the air circulation cutoff and you're up here to your brain for, like, 10 or 15 minutes, something is wrong.

We noticed that mom was in pain all the time. You couldn't even touch her—she would scream out. We saw that she wasn't doing so well. We didn't know what else to do. We thought the doctor was supposed to be doing what he could, and every time we touched her she pulled back and screamed. She would cry out in pain. We didn't know what to do. We thought she had a doctor who would take care of her, but evidently that didn't happen.

Finally, she had so much pain that we thought, well, it's time to take her to the hospital. My sister and I met at the nursing home at about 10 o'clock at night that evening. I had already been there that day. The doctor told us that he couldn't do anything—or the hospital could not do anything that he didn't do. Then we met Ann See. I looked at her and I told her I said, my mom is dying and I don't know what to do and from on she helped us. We were very relieved. We got mom on November 11, with Ann's help, and we transferred mom to RMH. We were very relieved.

After she was admitted to the hospital, they cleaned her sores and they kept her off of it. They put pillows beside her and propped her over. They fed her through her veins, and, best of all, they started giving her some pain medication intravenously.

I also have some pictures here I would like to show you all—this won't take too long. I'll pass them around so that you can see them a little closer. May I pass them around?

The CHAIRMAN. Sure.

Mrs. MESSERLEY. Mom stayed in the hospital. She was there for a week to 10 days and she was transferred to the hospice unit where she later died. For that month before she had died, she didn't open her eyes and talk to you or do much of anything. I went in the hospice the morning they were bathing her and they were turning her, and I was standing there. And when they turned her over, she kind of opened her eyes and looked at me, and that's the last time she opened her eyes and I told her I loved her.

She kind of went on back to sleep, and then maybe a half an hour or so later the nurse told me she had passed away.

Virginia did not enforce the nursing home laws. I think if the nursing home had followed these laws, mom would not have been restrained like she was and they would have checked her medicine and got it right so that she could still communicate with us. The nursing home law would have provided my mom. They would have given her a proper chair to sit in, it would have freed her from the restraints, protected her from being strangled, prevented the bed sores, let her live longer and made life better for her.

I really hope that—we don't know what we're going to go through before we die. It may be one of us that may have to go through this—I hope not. I hope we keep the laws to protect each and every one of us so it doesn't happen to us.

Thank you.

[The prepared statement of Mrs. Messerley follows:]

PREPARED STATEMENT OF GLORIA MESSERLEY

Thank you for allowing me to speak here today. My name is Gloria Messerley and I live in Linville, Virginia. I am here to tell you the story of my mother and her nursing home care. This is a picture of my Mom before she went into a nursing home.

Mom worked all through her life. She worked hard to raise her six kids. Every Sunday Mom would have dinner for all of us. Then the kids moved away. Time went by and Mom get forgetful. Still she would read her Bible, she went to the Senior Citizens' Center and mowed the lawn. My sister Alice was the one who would try to make sure that my mother remembered to take her medicine and that Mom's needs were met.

Mom became frightened of many things and we decided it was time to take her to the hospital. Mom never returned home.

After she got to the hospital the doctor wanted to run tests. He said she had Alzheimer. She stayed in the hospital for twenty-seven days. She went to an adult home for 6 days. Then they found a nursing home. It was a nursing home owned by a big company.

We admitted my mother to the nursing home on October 29, 1993. Mom was so furious with us. She said, "I can't believe you're doing this to me." When she first went to the nursing home, she could walk, feed herself, go the bathroom, and she went to Bingo. She won prizes.

Mom liked to walk a lot but they didn't like her to do that. The doctor gave her medicine. It finished her. She would just lay in the chair. The medicines were not helping her. The medicines made her groggy. She started peeing on herself. She started falling.

They started restraining her with things like this. They restrained her in a wheelchair and in the bed. We were dumb enough to ask them to make her safe. Then the sores began. In July 1994 she was admitted to the hospital for those bedsores. She went to the hospital many times. She went for falls, for cuts, and she fractured her hip twice.

October 20 is my mother's birthday. Last year the night before her birthday they called my sister Alice. They said they found my Mom hanging over the bed by her restraint. She turned blue. From that day she wasn't the same again. She could not eat right, she could not drink right, she could not talk the same. Later they told us that they thought Mom had a stroke.

We noticed that my Mom was in pain all of the time. We saw that she wasn't doing too well. Every time we touched her she pulled back. She would cry out in pain. We didn't know what to do. We thought she had a doctor who would take care of her.

Finally she had so much pain we thought, "it's time to take her to a hospital." The doctor told us that the hospital could not do anything that the nursing home was not doing. That night we met Anne See for the first time. I told her, "My mother is dying and I don't know what to do about it."

On November 11, 1994, with Anne's help, my mother was transferred to the hospital. We were so relieved. After she was admitted to the hospital they cleaned her decubitus; they kept her off of the sores; they fed her through her veins; and best of all, they started giving her pain medicine intravenously. Here are some pictures of Mom after she went in the hospital.

Mom stayed in the hospital, they transferred her to the hospice unit where she died. For the month before she died, my Mom never opened her eyes. The day that she died she opened them and looked at me.

Virginia did not enforce the Nursing Home Law. If the nursing home had followed the law Mom wouldn't have been restrained like she was and they would have checked her medicine and got it right.

The Nursing Home Law would have protected my Mom. It would have:

- given her a proper chair to sit in
- freed her from restraints she didn't need
- protected her from being strangled
- prevented the bedsores
- let her live longer, and made sure she had a real life while she was there.

Please leave the Nursing Home Law alone. It won't help my Mom, but if you make the States enforce it, it will help other people.

Thank you.

The CHAIRMAN. Thank you, Mrs. Messerley.

Do you have a statement, Ms. See?

Ms. SEE. No.

The CHAIRMAN. Do you wish to make a statement?

Ms. SEE. Yes, one of the things that I would like to explain is both Ms. Manning and Mrs. Messerley live in Virginia, and the nursing homes they were dealing with were in Virginia. One of the things I'm very concerned about is if there isn't any Federal oversight, Virginia just will not do anything to help nursing home residents, and I would like to give you a couple of examples.

Mrs. Messerley mentioned that her mother was in a nursing home and one of the things that we have found is that the Nursing Home Reform Act is an excellent law and it provides wonderful protections, but in the State of Virginia they do not enforce those regulations. I don't know if you've ever seen this before, but this is a book that the National Senior Citizen's Law Center put out where they did an analysis State by State of how the States were enforcing or implementing the nursing home laws, and I would like to just read to you a very small portion here about the use of sanctions. They responded that the process to sanction facilities is very expensive and the State is not using it. The Attorney General is also fearful of using sanctions because of a fear of countersuits by the facility.

To my knowledge, Virginia has never placed any sanctions on any nursing homes at all, and the nursing home where Ms. Biller, Mrs. Messerley's mother was, I can tell you that in July 1994 that particular nursing home had 26 pages of deficiencies; in April 1994, 16 pages of deficiencies; in April 1993, 11 pages of deficiencies; August 1993, 17 pages of deficiencies; July 1992, 13 pages of deficiencies. I have very similar figures—and I have all these surveys here so you can see that it's quite a lot of paper.

The nursing home that Ms. Manning's husband was in similarly in April 1994 had 16 pages of deficiencies and so on.

Basically, the nursing homes knew that the State of Virginia was not going to do anything to them, and that's why the enforcement part of the Nursing Home Reform Act is so very important because we have a good law and we need to enforce it. Based on my experience with the State of Virginia, they will not do that unless they are forced to, and I would like to give you just a couple of examples of that.

One of you mentioned that restraint use was very high, over 40 percent or something like that. In Virginia the restraint usage was 42 percent and they were not doing anything to try to reduce the use of restraints. So HCFA, Region 3, came down to Virginia and talked with them and then helped with the training and started a restraint reduction task force, and it's now down to—I believe it's 22 percent.

So they also when they came down said that they didn't have enough surveyors, they didn't have enough people to do the inspections and force the State of Virginia to hire more surveyors to do inspections because they were not doing any follow-up inspections at all. They are approximately 500 or more complaints behind. So when a complaint is made to them, they usually don't even go out and investigate until the next time there is a survey, and so it has not been very helpful at all.

The CHAIRMAN. Ms. See, we're going to move on to some questions if you could just conclude your statement.

Ms. SEE. It's just very important that we keep the Nursing Home Reform law. I'm very concerned about what will happen if we lose it, particularly in Virginia. I realize that there are some States who do a good job, but I don't think—based on my experience Virginia has not shown any interest in protecting their residents, and I'm very frightened that if the block grant goes to them and they're allowed to set their own regulations, the residents will not be properly protected and I think they need that Federal oversight also because, as in the examples I've given, the only time they did anything is when they were forced to by HCFA.

The CHAIRMAN. Thank you, Ms. See.

Let me say as a general proposition most nursing homes try to do a good job.

Ms. SEE. Well, I——

The CHAIRMAN. Let me just finish, if I could. Nationwide I think over the years as a result of the illumination of the problem, exposure of the problem, legislation that has been raised, and regulations that have been implemented by the executive branch, there has been a dramatic improvement from where we were in the 1960's and 1970's to where we are today. Most States try to do a good job. Most nursing homes—at least the really reputable ones—try to do a good job.

The fact is, there is no State that is immune from those who are either derelict in their responsibilities or who abuse their patients. Maine is not immune from it. We have two homes currently that are non-compliance that I could point to. There is not a State—maybe Montana. I haven't looked specifically at Montana. Maybe

Senator Burns is correct that they don't need these kinds of protections.

But the first problem is, enforcement standards. The law has been in effect before all of you were faced with this problem.

Ms. Garrison, when you went to the first nursing home, I assume you didn't see a nursing home patient's bill of rights posted in the nursing home. That's required. They're required to inform you of that. They're required to make an assessment of what your mother's needs were at that time. None of that occured—and we had the law in effect. So it's not a question of just having a law, or just having standards, that's only part of it. What Ms. See is talking about is the enforcement side of things, and that is the difference. You can have all of the laws but if you don't have adequate oversight and enforcement then they are ineffective. The law to date has been in the position saying, if we find violations, we have one of three choices: we can ignore the violations, we can give you verbal castigation or we can shut you down, and those have been the three options. They would rather keep the home open, particularly in a rural area, saying, well, it's not quite up to sufficient standards but better that it's open and doing poorly than not open at all. That has been the practice in the past.

As a result of the law that Senator Pryor and I and others have worked on all of these years, the Federal authorities now have a range of options that they can apply in the way of sanction such as imposing civil monetary penalties. Ironically enough the regulation which allows the imposition of civil monetary penalties just went into effect in July of this year and is now just starting to take hold. We're saying, no, we find you in non-compliance. We are not going to shut you down. We're going to give you a chance to correct it. We're going to, if we think it's severe enough, impose a civil penalty. We may suspend your right to take in additional nursing home patients. We may put in new management because we think the management is so poor. Or if violations are severe, we may shut it down. We have a range of options—that's part of the enforcement that exists under OBRA 87, as we call it, which is being wiped out under this block grant approach.

So it's one thing to have these standards. They were in place when you took your mother in. They were in place when you took your husband in. They were in place with your mother as well, and still they were not abided by, and so you have to have fairly vigorous oversight. They have to know that somebody is watching, that someone will come in unannounced. It used to be that the inspectors would have to give notice when they came so the nursing homes would clean the place up and everything would be spic and span and then as soon as the inspectors left, it was back to the same old process again.

Well, they can't do that now. There are unannounced inspections. We want to make sure we not only have the standards, because under the block grant proposal, they're required to have standards roughly comparable to what exists in the law, but we also need to ensure the enforcement of those standards at the local level. That's the problem we have with the potential of having either a Virginia problem, or a Mississippi problem, or an Arkansas, Alabama, or Maine or any other State problem.

I must tell you, Mrs. Messerley, I look at this—you know, when most people think of bed sores, they think maybe of a rash or a little scratch that got infected. This picture here is so dramatic. I am tempted to take it to every one of my colleagues on the Senate floor and say if you think that we don't have a problem today, I want you to look at this. I want you to know how it is possible for any person to develop a condition like this and to go untreated. How is this possible in today's world? Then I want to see them say, "Well, let's leave it up to the States. We'll let every State take that into account."

I will take this, with your permission, and show it to my colleagues because this is something that they have to see. It's not a wholesale indictment of the industry. As I've indicated, the industry has been cooperative. The nursing home industry representatives on the third panel aren't coming here today to say, "We want you to get rid of these regulations." They have had a positive salutary impact.

So it's not the pressure coming from the industry. Most of the reputable ones want to see the standards, they want to see them enforced, they want to assure the people who are coming that they get good care. So we intend to work together, Senator Pryor and myself and others, to make sure not only of the standards but we have the Federal Government—yes, some call it Big Brother—we want someone looking over their shoulder saying, we're going to make sure that you enforce these standards, that you measure up to the responsibilities. You're getting $800 billion over the next 7 years as part of the Federal contribution to this process, and so we think that there is a Federal responsibility. We think there is a need for uniformity. We don't want to see a patchwork of 50 different levels of not only standards but enforcement—that's what we don't want to see so that you would have one set in Virginia, one in Maine, one in Arkansas, Mississippi, California, Nevada. And, of course, both of you were fortunate. You live close enough, both of you, Ms. Manning and Ms. Garrison. You live close enough to be checking up. Many people find themselves putting their parents or grandparents in a nursing home and they're miles away. They may be thousands of miles away so they have no opportunity to do this.

A couple of quick questions—I want to reserve some time for Senator Pryor to explore this issue.

Mrs. Garrison, I was curious—in terms of when you first went to the nursing home, and obviously you weren't told about any rights, and then you saw what they were doing as far as the medicine and you complained about it, right?

Mrs. GARRISON. Right.

The CHAIRMAN. And what was the response of the nursing home at that time?

Mrs. GARRISON. They told me, "All old people act this way."

The CHAIRMAN. So they have to be medicated?

Mrs. GARRISON. Right.

The CHAIRMAN. OK, and then you mentioned that your mother had some broken ribs. How did you know about that?

Mrs. GARRISON. They would always call and tell me when she had an accident, but nobody ever saw it or anything. They couldn't

tell me how it happened, but as far as the accidents, they always called me and told me that she had had an accident.

The CHAIRMAN. Did you ever talk to the physician? Was there a physician that was associated with the nursing home?

Mrs. GARRISON. I never talked to him, never met him.

The CHAIRMAN. And so did you complain about the quality of care that your mother was getting?

Mrs. GARRISON. Oh, yes, sir, all the time—all the time.

The CHAIRMAN. And the answer was what?

Mrs. GARRISON. Nothing to worry about. All old people act this way. That's the only answer that I could ever get out of those people.

The CHAIRMAN. OK, so then you went to a hospital, right?

Mrs. GARRISON. Right.

The CHAIRMAN. And then you went to a second nursing home.

Mrs. GARRISON. Right, and they gave me a copy of the rights and everything, and that's when I found out that we did have rights.

The CHAIRMAN. But you still had some problems at the second nursing home.

Mrs. GARRISON. Yes, we did.

The CHAIRMAN. So you had the book and the bill of rights, so to speak, but you still had problems.

Mrs. GARRISON. That's right.

The CHAIRMAN. And when you complained about it under those circumstances, what happened?

Mrs. GARRISON. They started—we kept on and kept on and they started treating my mother a lot better.

The CHAIRMAN. So in the absence of you being present to complain nothing would have been done?

Mrs. GARRISON. Right, I was constantly complaining about it.

The CHAIRMAN. And you finally complained enough that apparently they provided the kind of care that was necessary, and your mother came home.

Mrs. GARRISON. That's right, my mother is home today.

The CHAIRMAN. And compared to you, Ms. Manning, they told you that your husband was going into a nursing home that no one ever came out of, right?

Ms. MANNING. Yes, sir.

The CHAIRMAN. Now did you know about any rights when you went in?

Ms. MANNING. I'm sure they read me the rights. At this time, you know, a lot is going on and it was confusing, but I'm sure they did. I do remember them telling me that and I kind of wondered about it.

The CHAIRMAN. Did you complain about the fact that——

Ms. MANNING. I complained. I even called a meeting at one of them.

The CHAIRMAN. Did you complain about the $20 a day or week that your husband was giving to Jerry?

Ms. MANNING. Yes, sir, I did.

The CHAIRMAN. And what was their response about that?

Ms. MANNING. I think the gentleman got fired.

The CHAIRMAN. Apparently, your husband continued to rap the side of the bed, right, to get attention?

Ms. MANNING. Yes, sir.

The CHAIRMAN. And that's when they put him on the floor?

Ms. MANNING. Yes, that was—they threatened him first, and then——

The CHAIRMAN. Did you complain to the doctor after your husband was put under the bed next to the air conditioning unit and developed pneumonia?

Ms. MANNING. Yes, sir, I did.

The CHAIRMAN. And what did the doctor say at that point?

Ms. MANNING. It was, like, a punishment. They said that Mr. Manning was a very difficult patient to attend to.

The CHAIRMAN. So, in essence, we will afflict him with pneumonia in order to teach him not to misbehave?

Ms. MANNING. Yes, sir.

The CHAIRMAN. And so then he went to the hospital?

Ms. MANNING. Yes, sir.

The CHAIRMAN. Did any one at the hospital complain or did you complain about the kind of treatment he was getting there?

Ms. MANNING. Yes, sir, I called his doctor and talked to his doctor about it, and his doctor told me the same thing—that David was a very difficult patient to take care of.

The CHAIRMAN. And they treated him for the pneumonia at that point?

Ms. SEE. Senator Cohen?

Ms. MANNING. Yes, sir. He also had bed sores—I'm sorry.

The CHAIRMAN. He had bed sores?

Ms. MANNING. Yes, sir, he also had bed sores too.

The CHAIRMAN. Was that because of the restraint?

Ms. MANNING. Yes, and I guess being in bed not being rolled over, you know.

The CHAIRMAN. Was he also tied?

Ms. MANNING. Yes, sir. Mine was like a jacket and he put his arms in it and it went around him and then it was tied to the bed.

The CHAIRMAN. And I assume they told you that was necessary in order to keep him from falling?

Ms. MANNING. Yes, sir. I think more or less too to keep from banging. You know, he couldn't use his arms.

The CHAIRMAN. And you had a similar situation, Mrs. Messerley, with your mother put in restraining straps as such?

Mrs. MESSERLEY. Yes, sir.

The CHAIRMAN. Did the nursing home ever indicate to you that there are other ways of protecting her from falling other than using a restraining device?

Mrs. MESSERLEY. Well, they put her in a wheelchair with a restraint in front of that. That's not tied around her; it's in front of her but she is still restrained.

The CHAIRMAN. Did you complain about the restraints at all or did you think they were necessary to prevent her from falling?

Mrs. MESSERLEY. Well, we were kind of dumb about the situation. I just—we thought and were dumb enough to ask them to put something in front of her because if they didn't, she's going to get up. And when she goes to get up, if she is groggy or off-balanced, she falls and cuts a hole in her head. I mean, I don't know whether

to have the hole in her head or something in front of her to keep her from getting up.

The CHAIRMAN. Ms. Manning, you indicated that your husband was found in pretty unsanitary conditions—soiled?

Ms. MANNING. Yes, sir, very much so.

The CHAIRMAN. Did you complain to any regulatory—did anyone here complain to a State regulatory agency saying, "This is the way my husband was found as far as the treatment for dialysis and the changing of the bag, and then being allowed or forced to lie in his own waste?" Did anyone—did you complain to a State agency and were you told anything if you did?

Ms. MANNING. At this time a lot was going on and I was so upset, but I am sure that I complained and I had one to go check, and at that time I don't even remember what the reply was.

Ms. SEE. Senator Cohen?

The CHAIRMAN. Ms. Garrison, did you——

Mrs. GARRISON. Yes, I complained to the State on both of the nursing homes my mother was in.

The CHAIRMAN. And got no response?

Mrs. GARRISON. They would say that my suspensions were true, but they were going to be fixed, the nursing homes would agree to fix them, but there never was.

The CHAIRMAN. Ms. See, did you have a question?

Ms. SEE. Well, I was just going to explain because I was working with both Ms. Manning and Ms. Messerley. A complaint was made for Ms. Manning to the State ombudsman and they did come out and investigate, and it was a founded complaint. Adult Protective Services was contacted, and their investigation came back unfounded, but we don't know how they did that because he was in the hospital when they did the investigation and he never talked to any one in the family. Similarly, Ms. Messerley's complaint has been filed and we're still waiting for a response from them on their report.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Thank you, Senator Cohen.

I think that what we have here are three extremely sensitive, loving, caring daughters who went to the rescue of their parents in nursing homes, and we applaud you for that. As we cited earlier, most of the people in America's nursing homes today as residents have no relatives to look after them, to check on them, and to become their advocate.

My question is to you, Ms. See, what happens to all the rest of the resident population of nursing homes when they don't have relatives to look after them and plead their case? What are their, let's say, opportunities to protect their interests?

Ms. SEE. Well, it's very poor, and, again, in Virginia we do not have local ombudsman in every area of the State. So particularly in our area, through the Shenandoah Valley, we do not have a local ombudsman. If we did, then there would be somebody locally that they could contact.

Senator PRYOR. Do most States have a local ombudsman, do you know?

Ms. SEE. Well, I think the answer to that is yes, but I'm not quite sure.

Senator PRYOR. I understand. We will try to find that out ourselves.

Ms. Garrison's mother at the nursing home, would you ever send your mother back to a nursing home after this experience—maybe that's not a very fair question.

Mrs. Garrison. Yes, I would because there is good in nursing homes. You just have to be on top of it. You have to watch and be on top of it. I think it's good because there around people in the same kind of shape they are.

Senator PRYOR. Did you find a difference—and I'll ask this to the three of you—did you find a difference, let's say, in the care received by your relatives and parents in the homes in the day time period as compared to the evening shift or the evening period? Was it different at night than in the day?

Mrs. GARRISON. Yes, sir.

Senator PRYOR. And was it better or worse at night?

Mrs. GARRISON. It was worse at night.

Senator PRYOR. Worse at night. What about you, Mildred Manning? Is that what you think?

Ms. MANNING. Every time I always went in, it was bad no matter what time.

Senator PRYOR. Night and day. All right, Gloria Messerley?

Mrs. MESSERLEY. Night time was usually worse.

Senator PRYOR. Night time was usually worse?

Mrs. MESSERLEY. Yes.

Senator PRYOR. You know, one of the key components of the 1987 legislation is the staff training that is required. Now we're talking about Jerry here who is taking 20 bucks every time he would take your father to the bathroom. I don't know how you ultimately rid our society of those people who will do that, but this is one of the great concerns that I see if we don't reinstate these standards. Senator Cohen and I have talked about this, and that's another reason that I think that we should reinstate those.

One other point that I think might be good to just mention to put on the record is the need for some kind of standards whereby in the future if Dorothy Garrison puts a loved one in the nursing home and you live in Virginia, I believe. Is that correct, you live in Virginia?

Mrs. GARRISON. I live in Alabama.

Senator PRYOR. Oh, you live in Alabama? Well, let's say if you put someone in the nursing home and they live in Florida and you live in Alabama. You will know in Alabama what the Florida regulations are that will be overseeing your relative in that nursing home there because all of the regulations on the Federal level will be standardized, and that way we all know the rules and we all know what the standards are. I think that's a very, very good part of being a standardized process, of regulations and standards.

So I think with that, Senator Cohen, I want to thank our three witnesses today too. It took a lot of courage to come here, and it's not easy to talk about this. We know it's been very, very helpful to us.

Thank you.

The CHAIRMAN. Let me just conclude with some final words to this panel and share what Senator Pryor said about our thanks and gratitude for your coming.

One of the things we have found—Senator Pryor and I have found—while serving on this Committee—and we go back a long time together. He was in the House even before I was in the House, but I've been on the Aging Committee since 1975 when it was first initiated in the House of Representatives.

One of the things we found, aside from nursing home patients, is when people come to testify before our Committees investigating fraud we find that people are often afraid of exposing abuses of the system.

Older people, do you know what they're afraid of? They're afraid of retaliation by an agency. Here are people who are living in their own homes who have support systems all around them. They are afraid to raise questions when they see wrongdoing taking place for fear there will some sort of retaliation against them.

Now, you should consider that because we have had very courageous people come forward and say, no, this is wrong. I've got to speak out against this, and we could give you example after example where people have. But the initial reaction is fear, don't rock the boat, don't complain, or the authorities will turn against you.

Imagine the fear and terror that most people who go into a nursing home or into an institutional setting where mother, father, sister, brother—family members are not there. They are in the hands of strangers, you come and visit and they say, "This is what is being done to me. I'm going to be on the floor tonight, or I'm being restrained," and you complain about it, the fear is that they will have to pay a penalty. They're the ones, for having told you, who will have to pay the penalty, and they're the ones who will have to wait through the night in terror and in fear that somehow they're going to receive punishment.

So this is something that we have to keep in mind, saying that we want qualified, good nursing homes who not only have the standards that have been set by the Federal Government as such, but are dedicated to complying with the standards, rather than running the kind of institutions where you can go in and find your husband, Ms. Manning, as you did.

So this is part of the reason we're holding this hearing today. I had scheduled it actually for last Thursday but it had to be postponed for other reasons, but it is timely in the sense that today and tomorrow we will be debating and deciding on whether or not we keep the standards and the enforcement in place to make sure that we do the best we can. We are never going to correct all the problems. There are always going to be abuses, there will always be violations, there will always be people who slip through the net. Let's face it—some people are difficult as they get older, but you still have to treat them with loving care in a humane fashion and not resort to punishment or psychological terrorism in order to try to modify their behavior.

Anyway, we have to move on because we're going to start voting I think around noon time and we've got two more panels to proceed, and I want to thank each of you for coming and telling us some very moving, poignant stories.

Thank you.

Mrs. MESSERLEY. Thank you.

Ms. MANNING. Thank you.

Mrs. GARRISON. Thank you.

The CHAIRMAN. Our second panel includes Scott Severns, the president of the National Citizens' Coalition For Nursing Home Reform. Mr. Severns will describe how the OBRA 87 regulations came about and the significant improvement in nursing home care since the regulations have been in place.

Our second witness, John Willis, is a State Long-Term Care Ombudsman and is testifying on behalf of the National Association of State Ombudsman Programs, Mr. Willis is going to describe how these laws are used by ombudsman programs across the Nation to fight for quality care on behalf of nursing home residents.

They are joined by Ellen Reap, the president of Association of Health Facility Survey Agencies in Wilmington, Delaware.

Catherine Hawes is a senior policy analyst and co-director of Long-Term Care, Research Triangle Institute of North Carolina, and they're going to present testimony about improvements in the quality of care and the significant Medicaid and Medicare savings that have been achieved through the implementation of OBRA 87 nursing home standards.

Mr. Severns, perhaps we should begin with you.

STATEMENT OF SCOTT SEVERNS, ESQUIRE, PRESIDENT, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, WASHINGTON, DC

Mr. SEVERNS. Mr. Chairman, Senator Pryor, and members of the Committee——

The CHAIRMAN. Could I request that you try to summarize as best as possible so we could have your full testimony included as part of the record and then we'll ask some questions. We want to make sure that we don't leave everybody here abandoned when the votes start going off.

Mr. SEVERNS. I want to express the gratitude of nursing home residents, family members, long-term ombudsman, and citizen advocates from across the country for your holding these important hearings.

Senator Pryor pointed out the scope of the changes you are considering are just overwhelming, and we find ourselves actually caught up in a whole ideological shift from those on one extreme who would say that the Federal Government is a source of all wisdom to those on the other extreme who say that the States can inherently do it better.

As usual, the truth lies somewhere in between, and each law needs to be evaluated on its own merit. When you evaluate laws, we hope you will consider the integrity, the commitment, the breadth of representation and the knowledge of those who contributed to it.

You've heard the stories from nursing home residents, and I want to tell you another story. It's a story about a dream that was conceived a little over 20 years ago. It was a dream dreamed by the founding director of the National Citizens' Coalition For Nursing Home Reform, Emma Holder. She had had experience with

Oklahoma nursing homes and had a strong conviction that the best solutions to problems spring from the people who have the most direct experience with them.

Her experience took root in our organization as it was formed, and it became a voice for the people who live in long-term care facilities. I became caught up in that dream in 1979. At the time I had become director of a nursing home ombudsman program in Indiana. It was the first sub-state. I came to Washington and participated in the annual meeting of the National Citizen's Coalition for Nursing Home Reform, and that's become a pilgrimage every year since. I have carried it forward into my private practice of law where I serve primarily older people and people with disabilities.

In 1981 there was a similar ideological conflict in shift, and there was a proposal to deregulate the nursing home industry. Public response built and crescendoed to a public outcry. The stories of the abuses and the indignity that were suffered by thousands of people in nursing homes throughout the country began to come forward again.

Congress responded to that outcry then by commissioning the Institute of Medicine to conduct a study of the quality of life in nursing homes. Our own organization received a grant from Robert Wood Johnson to go to the experts. We were able to go to nursing home themselves them, "What contributes to quality from your point of view?" Our study, The Nursing Home Quality Residents perspective, became the foundation for the Institute of Medicine's report, and in 1986 the Institute of Medicine released its report improving the quality care of nursing homes, which in turn became the blue print for the nursing home reform law. During that whole period this Committee was holding hearings and learning the stories that people have to tell similar to what you've heard today.

The following—the release of that report, the National Citizens' For Nursing Home, brought together professionals, providers, citizen groups, and stakeholders of every type in the nursing homes field into a campaign for quality care, and over the months that followed, we hammered out, we discussed, we aired differences and we came to consensus positions, and that created the unique solidarity that stood behind the enactment of the Nursing Home Reform Law of 1987. This Committee helped forge the language of that historic act.

The Nursing Home Reform laws have brought about dramatic improvements in the quality of life for nursing home residents. We now know that 142,000 people in nursing homes today are not tied up, who would have been tied up a few years ago. We now know that the Medicaid program has saved about $2 billion a year from hospitals that are now no longer necessary because people are not being neglected and used in the same numbers they were before. Most of the people I see in my office have been care givers for years prior to reaching the point when home-based care is no longer possible. They seek a constructive role on behalf other nursing homes and a confusing one, not just to be a casual visitor. The laws give them the framework. It gives them the framework in Indiana, Montana, in Florida and Washington, and we can talk about the same framework through the country because of the uniformity of the law.

The law has brought about dramatic improvements and the education of the use of psychoactive drugs, one hospital discharge plan or observers. We don't drug residents into a stupor as much. There is much more rehabilitative theory, better and safer nursing, more activities. And, more importantly there is a stress on the person as an individual, making the nursing home adjust to the individual instead of treating each person just as another older person.

Our own board member, Janet Tellis, a long-time resident of the Washington home in the District, here said that the Nursing Home Reform Law was at the beginning of restoring autonomy to those who thought they lost it because of physical dysfunction. Janet suffers from cerebral palsy, and had spent most of her life in an institution.

I'm proud to say that our board has always had nursing home residents. We have three nursing home residents who are very active participants in the work of the coalition—Kermit Forte from the D.C. Village Nursing Home is here today—but about a half of nursing home residents have no one who looks after them. They have no one who looks in on them, and they depend on the structures of law and on the programs that serve to protect such as the nursing home ombudsman program, the survey agencies of the State's legal services program, such as the one that Anne See works for, to protect them and provide them with access to advocacy services.

We have documented the high cost of poor care. In a 1993 study published in the American Journal of Public Health they found that residents who are physically restrained require more nursing care than their unrestrained counterparts—at least they require more care if it's done right, and if it's not done right, the consequences can be death or very costly hospitalizations.

One of the things that concerns us most about the proposal to block grant Medicaid is the separation of long-term care from the acute system in Medicare. If States are told that the long-term care problem is your problem, you take this money and do what you will with it to provide for long-term care, when people go from nursing home to hospital because of neglect, the State is actually going to realize a financial advantage because the State will no longer be responsible for caring for that patient in a hospital because Medicare will take over. When patients are malnourished, trays brought in but never given the assistance they need to eat, it leads to bed sores, it leads to infections. When the all too common diagnosis from the hospital is dehydration, it very often reflects neglect that has gone on in a nursing home.

The quality of care provisions of the Nursing Home Reform Act are designed to prevent these poor and costly outcomes, and they are working. They are beginning to make a difference. Skin break down is not a normal thing in normal people, dehydration is not a normal thing and the infections that result. And it can cost from $4,000 to $40,000 to care for a patient who has developed bed sores. The total annual cost of bed sores in this country are estimated to be $1.2 to $12 billion, and approximately 20 percent of nursing home residents have developed bed sores in the past years.

As taxpayers, we're concerned about the future of Medicare and we're concerned about what will happen if people in need of long-

term care services are told that the Medicaid system pays for them in the nursing home and that's a State problem, but when they get sicker and are abused and neglected they go to Medicare, the Federal system.

We're encouraged by movements to unify Medicare and Medicaid. Senator Dole's proposal to increase the replication of the pace program, which brings together Medicaid and Medicare funding into a single source of service. It holds promise because it brings together and allows coordination of the care. It allows the cost of poor care to be realized by the people who perpetuate it.

We must be careful of managed care. Managed care companies have virtually no experience with long-term care. They have shunned that undertaking, but the idea of managed care and bringing those things together is certainly worth looking at.

Some people have asked, couldn't the good work that has been done in the nursing home reform law be repeated in 51 jurisdictions? Our answer is yes, eventually. Eventually people with the integrity of Emma Holder, our director, would spring up in each State and would advocate and create a vision for better care. With enough time and resources providers committed to advancing quality would emerge in leadership roles. With enough time and resources regulators and researchers in each State would learn the enlightened practices that came from the Institute of Medicine study and are reflected in this law.

But how many of our mothers, fathers, grandparents, husbands, wives, and children with disabilities will be bound up to their beds while waiting for these enlightened practices to be re-established under the new order? What will be the cost to America's employers of lost productivity of people whose gut-wrenching experience of trying to work is knowing that a parent at home is either going unsupervised or is being cared for in a nursing home that was selected by the State on the basis of being the lowest bidder without any uniformed standards? How many billions of dollars will the overburden Medicare system pay to fix broken bones, treat infections, and debrided rotting skin resulting from neglect? How long will it take for children in one State to learn what they must know in another State to effectively advocate for a nursing home resident if there are 51 different laws?

These costs of waiting, of re-establishing, of reinventing the bill will be steep and potentially deadly for our country's elderly and disabled.

The final phase in the nursing home reform law took effect on July 1 and brought about enforcement. Senator Cohen, you mentioned the need for vigorous oversight, and while I can certainly underscore that, prior to that date in Indiana our situation was very much like Virginia, and we had experienced the same sorts of neglect of problems over and over again. I'm proud to say that the Indianapolis Star has been joined now by the New York Times representing the full political spectrum in support of this law, and it's based on the experience that this law has brought about in Indiana ringing enforcement for the very first time.

The CHAIRMAN. Mr. Severns, if you could summarize quickly your statement.

Mr. SEVERNS. There have been problems with the implementation of the enforcement system since July 1. We always have bumpy roads. We will hear providers say that they are fearful of being dinged when they are trying to do a good job, and indeed I think we would all have that same reaction if all of a sudden we were faced with the potential for fines for breaking speeding laws if we had never had that before, but it is critical that we move forward. This law gives providers, advocates, ombudsman, and families the basis for dialog for working these things out, and it is so critical that this law be upheld and that the services and the quality of life to nursing home residents in this country be protected.

We thank you again for holding these hearings and we count on your support.

[The prepared statement of Mr. Severns follows:]

PREPARED STATEMENT OF SCOTT R. SEVERNS

Senator Cohen, Senator Pryor, and Members of the Committee: I bring you the gratitude of nursing home residents, family members, long-term care ombudsmen, and citizen advocates for holding this important hearing at this critical time. My name is Scott Severns. I am president of the National Citizens' Coalition for Nursing Home Reform. My daily work is in a private law practice working with people who are elderly or have disabilities and their families.

Our nation's long-term care system is caught up in an ideological shift separating those who, on one extreme, believe that all wisdom and truth must come from the Federal level, to those on the other end of this divide, who claim that State governments are inherently more in touch with and more capable of responding to their citizens' needs. The difference of viewpoints is as old as the Constitution itself. Today, as in times past, the truth lies between the extremes. Any structure created by law must be evaluated on its own merit. That evaluation includes the reason for which the law was created, and the integrity, commitment, breadth of representation and knowledge of those who contributed to its emergence and development.

You have heard the stories and experiences of nursing home residents' families. I want to tell you another story. It is the story about a mission that was conceived just over 20 years ago. It is a story in which this Committee played a major role. It is the story of a mission that has begun to be realized.

In 1975, the Coalition's founder and Executive Director, Elma Holder, had a vision for a better life for people in nursing homes. Her experience with Oklahoma nursing homes, and her conviction that the best solutions to problems spring from the experiences of people who are most affected by them, took root in a small organization called the National Citizens' Coalition for Nursing Home Reform. Over the years many others were moved to action by her vision, her integrity, and her commitment. As the director of the first sub-state Long-Term Care Ombudsman Program in Indiana in 1979, I was one of those people captured by that vision.

In 1981, in an atmosphere of ideological conflict similar to today's, a proposal was advanced to deregulate nursing homes. Public response crescendoed to a national outcry about the indignities endured and the harm suffered by thousands of American elderly and disabled citizens. Residents, their families, and nursing home providers agreed that the existing standards for the regulation of nursing homes—and the way that those standards were enforced-fell tragically short of meeting the needs of America's elderly and disabled. Although proponents on each side of this issue approached the question from different perspectives, everyone recognized that there must be a better way.

Congress responded to America's concern by commissioning the Institute of Medicine to conduct a study on this subject. Meanwhile, the Coalition received a grant from the Robert Wood Johnson Foundation to go directly to nursing home residents across the country to seek out residents' perspectives on quality of life in America's nursing homes. Our report, *Nursing Home Quality: The Residents' Perspective,* became a foundation for the work of the Institute of Medicine. The IOM report, *Improving the Quality of Care in Nursing Homes,* in turn became the foundation of the 1987 Nursing Home Reform Act.

During this same period, the Senate Special Committee on Aging held extensive hearings to document the problems with nursing home care and nursing home regulations.

Following the release of the Institute of Medicine study, the Coalition brought together professional, provider, and citizen organizations representing virtually all stakeholders in the long-term care system into a Campaign for Quality Care. Over months of intense campaign meetings, consensus positions were adopted and differences openly expressed to create a unique solidarity of support for the Nursing Home Reform Act of 1987.

This Committee then helped forge the language of this historic Act that was enacted with strong bipartisan support.

THE NURSING HOME REFORM ACT HAS BROUGHT DRAMATIC IMPROVEMENTS IN QUALITY OF LIFE AND CARE FOR NURSING HOME RESIDENTS.

Shortly after the Nursing Home Reform Act's enactment, progressive providers dramatically demonstrated how residents suffering from confusion could be humanely cared for without resorting to physical and chemical restraints. We now know that more than 142,000 people living in long-term care facilities have been untied, freeing both themselves and their care givers from the bondage of care practices which rob each of their dignities. Better care practices have significantly reduced suffering to residents, which is costly in both financial and human terms. One study has estimated a savings of $2 billion yearly in reduced hospital days for Medicare recipients. That is a staggering amount that the taxpayers did not have to bear.

It has taken 8 years for the Nursing Home Reform Act to unfold to the point where it is today, affecting tens of thousands of people in nursing homes and their families in every State. I can assure you that good care, humane treatment, and maintenance of reasonable health-care costs will continue to increase *only* if this law and the foundation upon which it is based are upheld.

The Nursing Home Reform Act commonly is described as "resident-centered." That simply means it focuses not on organizational structures or building codes, but on the actual delivery of care that meets each resident's individual needs. Under the law, these care practices must help to maintain or improve each resident's health and well-being. And they must be delivered in a setting that respects people's rights and dignity. It sounds simple, but it has led to dramatic improvements in care.

The key elements of the Nursing Home Reform Act include:

- Individualized assessment of each resident's abilities and needs.
- A plan of care, with specific goals, methods and measurements addressing residents' needs.
- A standard of care that supports the physical, mental and psychosocial well-being of each resident through supportive care, therapy, and resident and family participation.
- A standard for quality of life for each resident that provides for reasonable accommodation of individual needs and preferences.
- Protection of residents' rights to dignity and security, and freedom from abuse, restraints, and involuntary transfers and discharges.
- Training for nurse aides who deliver 90 percent of the care and attention to residents.
- Resident access to the long-term care ombudsman program for assistance when problems arise.
- Enforcement of standards through effective survey procedures that review the care from the resident's point of view, identify problems, assure correction, and apply appropriate penalties.

The Nursing Home Reform Act provides a framework for facilities to help each resident reach his or her "highest practicable physical, mental, and psychosocial well-being." What does this language mean? Here is how one health-care professional explained it in real-life terms:

> These Federal mandates * * * have changed the focus from "going somewhere to die," to "what is the best way (or ways) to care for this person to make him or her as independent as possible, or as comfortable as possible, or as content as possible." We don't drug residents into a stupor as much. There is more rehabilitative therapy, better and safer nursing, more activities. Most important, there is more stress on each person as an individual, making the nursing home adjust to the individual, instead of treating each person as "just another older person."
>
> Naomi Segal, hospital social worker, Philadelphia, PA

The Nursing Home Reform Act also steers facilities toward treating nursing home residents "in such a manner and in such an environment as will promote maintenance of quality of life with reasonable accommodation for individual needs and preferences." As one nursing home administrator has observed:

> The Reform Law has allowed a huge change of emphasis from quality of care to quality of life: from a medical model in which things are done to and for a resident to a model where a resident's choices and independence are the center of all activity.
>
> Bob Ogden, Administrator, Providence Mount St. Vincent, Seattle, WA

For one Kentucky nursing home resident, these provisions made a real difference.

> For 10 years, she worked in the housekeeping department of a Kentucky nursing home. Then she was diagnosed with a rare disorder of the central nervous system and at the age of 55 became a resident of one. Because Huntington's disease makes even slight changes to her daily pattern unbearable, adjusting to the nursing facility proved difficult. But the Nursing Home Reform Act's mandated assessment and family-participation requirements enabled her, along with her husband and three daughters, to work with the facility to ease the transition. She is now included in the decision-making and receives advance notice, in writing, of any changes in her daily routine. Disturbed by the noise and confusion in the facility's cafeteria, she eats in a small personal dining room, where it is calm and quiet. And, she sits in the same comfortable chair in the same familiar place each afternoon. The woman's youngest daughter said her family wouldn't have had a leg to stand on without the Nursing Home Reform Act supporting their right to leg to secure individualized care for their mother. "I would not feel right if we just left Mom in an institution for someone else to take care of all the decisions, "she said.

And, in the words of a longtime Washington, D.C., nursing home resident, the Nursing Home Reform Act:

> * * * was the beginning in restoring autonomy to those who thought they had lost it through physical dysfunction.
>
> G. Janet Tulloch, The Washing Home, Washington, DC

The Nursing Home Reform Act affords residents the right to be free from chemical and physical restraints, a protection that has brought far-reaching changes, according to this nursing home medical doctor:

> Where the Nursing Home Reform Act has been most effective is in physical restraint reduction and significantly reducing the use of psychoactive drugs. Without the Act, it would have taken us longer to have these changes implemented and how to have them as widely accepted. The Act allowed us to disseminate the medical knowledge with the impact of the law behind us.
>
> Monte J. Levinson, M.D., President, American Medical Directors Association

American has become an increasingly mobile society, with families often separated by vast distances. Therefore, the national quality standards encased in the Nursing Home Reform Act are desperately needed to guarantee decent care and appropriate services no matter where a resident lives, and regardless of whether he or she is fortunate to have a loved one looking out for them. About half of all nursing home residents do not.

THE HIGH COST OF POOR CARE

In an era where accountability for public dollars is imperative, I am pleased to report that outcome data on the Nursing Home Reform Act supports the long-held consumer view that providing quality care is cost effective, while allowing poor care to continue causes unnecessary suffering and avoidable costs.

According to a review of published literature, nursing home use of antipsychotic drugs—tranquilizers and other mind-altering chemicals—has declined about 30 percent since implementation of the Nursing Home Reform Act. The decline in the percentage of residents who are physically restrained has been even greater. Unpublished data from the U.S. Health Care Financing Administration shows use of vest restraints, leg ties, and other immobilizing devices has dropped from a high of 38 percent before the Reform Act to a low of 21 percent in 1994. Vermont and Iowa have each lowered restraint use below 8 percent. Such State leadership and experimentation within a common framework of Federal law shows what is possible.

Meanwhile, published studies support the cost effectiveness of restraint-free care. The outcome of restraint-free nursing home care includes residents who are more alert and independent, less prone to drug-induced falls, debilitating skin ulcers, and contractures that often require residents to undergo costly hospitalization.

It is not surprising that additional published studies show restraint-free care results in lower costs for nursing home care. A 1993 study published in the *American Journal of Public Health* found that residents who are physically restrained require more nursing care than their unrestrained counterparts, and thus are more costly to care for. Similarly, a 1993 study on reducing psychoactive drug use among nursing home residents in Georgia found monthly savings of $76,738 in drug expenditures. The study involved 9,500 nursing home residents, 85 percent of whom were Medicaid recipients.

More recently, preliminary results from another study support existing evidence that implementation of the Nursing Home Reform Act has brought measurable advancements. The study, to be published in a series of articles in 1996 used pre- and post-Nursing Home Reform Act data to evaluate the impact of the Resident Assessment Instrument. A key component of the Act, the Resident Assessment Instrument help facilities determine each resident's strengths and weaknesses. The study involved 4,000 residents in 26 nursing homes in 10 states.

Major findings from this preliminary research include:

- a 25-percent reduction in hospital use
- improved independence and stability among residents, even though the nursing home population in the years following implementation of the Nursing Home Reform Act suffer greater physical and cognitive impairment
- a 25-percent decrease in the use of physical restraints between 1990 and early 1993
- a 29-percent decrease in the use of indwelling urinary catheters

THE NURSING HOME REFORM ACT PROMOTES QUALITY, COST-EFFECTIVE CARE

The provisions of the Nursing Home Reform Act not only protect nursing home residents, but also save State and Federal dollars. Hospital care to treat the effects of neglect is extremely costly. When residents whose minds or bodies no longer support their ability to provide them with sustenance have food trays set before them and removed without being given the assistance they need, their malnutrition leads to bedsores and infections. When residents are not offered water, the all-too-common hospital admitting diagnosis is dehydration. When residents are not assisted to the bathroom, the resulting incontinence becomes a humiliating and costly way of life.

The quality-of-care provisions in the Nursing Home Reform Act are designed to prevent these poor, costly outcomes. They are working. And they are saving public dollars.

According to cost estimates for certain conditions from the literature, and pre-Nursing Home Reform Act resident-disability data from the Health Care Financing Administration:

- In 1990 the total health bill for incontinence in nursing homes was $3.26 billion. About half of all nursing home residents (795,000) were incontinent. At $6 per day, per incontinent resident, the costs for direct care totaled $1.5 billion. The consequence of incontinence—skin irritation, decubitus ulcers, urinary tract infections, additional hospitalizations—contribute to the estimated bill of $3.26 billion annually. Much of this is preventable when nursing homes carry out the quality-of-care provisions in the Nursing Home Reform Act.
- Skin breakdown is not normal for frail older people. Skin breakdown and resultant pressure ulcers occur most often when basic needs such as food, fluid, cleanliness, and mobility are not provided. Pressure ulcers are preventable, yet 20 percent of nursing home residents developed pressure ulcers. It costs from $4,000 to $40,000 per resident to treat these ulcers, depending on the severity. The total annual cost of treating pressure ulcers from $1.2 and $12 billion.
- Before passage of the Nursing Home Reform Act more than 35 percent of residents were physically restrained, and about the same number were given large, inappropriate doses of tranquilizers and other chemical restraints. Studies show that both types of restraints cause falls. Many lead to hip fractures. In 1985, 98,291 nursing home residents suffered hip fractures, indicating that $2.6 billion was spent on avoidable hospital care.

Provisions in the Nursing Home Reform Act have helped to avoid these costly poor outcomes. In many places, however, these uniform quality standards are just beginning to take hold. To date, we have only scratched the surface of the improvements in quality of care and life and resultant savings possible under the Nursing

Home Reform Act. Indeed, a recent independent investigation by *Consumer Reports* magazine found nursing home care in America ranges from "inadequate" to "scandalous" in part due to "erratic" enforcement of standards.

The recent implementation on July 1 of a new long-awaited Federal enforcement system holds out the promise for continued strides on behalf of residents and reduced government spending. Abandoning the Nursing Home Reform Act in midstream will mean the collapse of critical progress in quality, cost-effective care.

A BLOCK-GRANT SYSTEM WITHOUT FEDERAL STANDARDS WILL PROMOTE COST-SHIFTING TO MEDICARE

Consumers are concerned that if Medicaid is converted into block grants, States will be inclined to use their newly granted flexibility to forgo the uniform standards in the Nursing Home Reform Act. As a result, the quality of nursing home care will suffer, and the Federal Government will be faced with financing the resultant Medicare-covered hospital costs for nursing home residents. Any discussion of transforming Medicaid must explore ways to eliminate incentives for cost-shifting between the two programs and promote coordination between them to achieve a more cost-effective, streamlined approach to care. National standards of quality in nursing homes are essential to this coordination.

Like other advocates for long-term care residents, we are encouraged by the PACE Provider Act of 1995 sponsored by the Senate Majority Leader. Sen. Dole's proposed measure would pave the way for increased replications of the On Lok Pace program, a capitated joint Medicaid/Medicare model that in its limited application already has generated at least a 5 percent savings, while improving access to a range of long-term care services. Minnesota recently received a waiver to implement a pilot joint Medicare/Medicaid program serving elderly people.

Although managed care systems increasingly are providing health services to many Americans, older people with chronic illness have not been covered by these plans. Combining Medicare and Medicaid services under a single managed-care plan presents one avenue for exploration. However, it is important to bear in mind that managed care companies have virtually no experience with long-term care quality issues. Congress should thus proceed with caution in expanding managed care as a means to control health-care spending—remembering that, as the Nursing Home Reform Act has shown, quality care is cost effective.

NURSING HOME QUALITY IS A NATIONAL ISSUE

Mr. Chairman and members of the Committee, we recognize the urgency of controlling the Federal deficit.

You may ask "couldn't the good work that has provided the solid foundation at the Federal level be replicated in the 51 jurisdictions to whom it would be delegated?" My answer is, "Yes—in time." Given enough time, resources, and commitment, leaders with the integrity of individuals like Elma Holder would eventually spring up in each State to respond to poor conditions and to create a vision of better care. With enough time and resources, providers committed to advancing quality before financial gain would eventually put long-term quality above short-term profit, and eventually emerge in leadership roles for the industry. Regulators and researchers in State jurisdictions may, after time, absorb the knowledge and experience that have provided the foundation for the Federal nursing home reform law. But lacking the resources, guidance, and information available at a nationwide level, how much time will 51 separate jurisdictions take to develop comprehensive guidelines, and at what cost to America's elderly and disabled citizens in the meantime? And at what cost to taxpayers?

How many of our mothers, fathers, grandparents, husbands, wives, and children with disabilities will be in bondage while waiting for enlightened practices to be reestablished under the new order? What will be the cost to America's employers in lost worker productivity if those workers cannot concentrate on their daily tasks because of their turmoil over what may be happening to a parent going without care, or to a loved one whose care has deteriorated to the level of the lowest bidder, operating without standards? How many billions of dollars will the overburdened Medicare system pay to heal broken bones, treat infections, and debride rotting skin resulting from neglect? How long will it take for children living in one State to learn individual State rules that they must to know to effectively advocate for a parent in a distant nursing home because there is no common framework on which these rules are based? The cost will be steep, and potentially deadly to this country's elderly and disabled.

Less than three months ago, the final phase of the Nursing Home Reform Act was launched with the implementation of enforcement regulations. Like most of the

phases of implementation before this one, it has proceeded through natural bumps and curves on the road to a stable and reliable system. Providers committed to quality fear that they will be subjected to the embarrassment of sanctions when they fall short. The fear of consumers in that the effort at enforcement will become diluted by funding cuts and lack of political will, and chronic problems will continue to go unaddressed and violations of individual rights will continue to be ignored. As with each preceding phase of implementation, consumers and providers, researchers and regulators continue to conduct an active and constructive dialogue to resolve the fears and make the system work.

That dialogue between consumers, providers, researchers and regulators has been made possible by the foundation of this law. Without the law, we have no common language for reference. The purpose and principle of this vital law afford each side of the complex long-term care system a common, unified voice when we say that all services, all regulations and all enforcement must serve the purpose of enhancing the quality of life and quality of care for people the system is designed to serve and protect.

The Nursing Home Reform Act is a law that works for residents, for those who care for them and about them, and for taxpayers. On behalf of concerned and compassionate citizens nationwide, I urge you to help us make the dream of decent, quality of care a reality.

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WHY WE HAVE FEDERAL LEGISLATION
NURSING HOME REFORM -- A CASE STUDY

The current rush to turn vast amounts of federal money over to the states with virtually no strings attached is proceeding without any attention to the historical perspective that informs us why we have federal legislation at all. The origins of many pieces of federal legislation that are now threatened with block granting or with complete extinction could serve as model history lessons chronicling the failure of states, left to their own resources and devices, to address significant needs of the population and, in some cases, adequately to account for the expenditure of billions of dollars of public funds. One example that will resonate particularly with people of all ages and incomes who are facing or know someone facing the need for long-term care is the federal nursing home reform law.

Over 1.5 million people live in nursing homes. Some estimates suggest that 43% of Americans over 65 will use nursing home care at some time before they die. The federal nursing home reform law offers substantial quality of care and quality of life protections for those needing such care.

The reform law, passed in 1987, has been in effect throughout the country since October 1990. Its requirements reach the more than 75% of the nation's nursing homes that participate in either Medicare or Medicaid, facilities that received over $30 billion of public money in 1993. [Medicare and Medicaid, facilities are, respectively, the federal program for older and disabled individuals, and the federal-state program for low income families, children, older and disabled people.] The reform law is an unprecedented codification of high quality care standards coupled with a strong emphasis on determining and meeting each individual's needs. It has resulted in a dramatic decrease in the use of physical restraints in nursing homes, as well as decreases in inappropriate drug use and in the incidence of bed sores and incontinence. The standards required by the law apply to all who reside in the nursing home, not just to those whose stay is paid for by public programs.

Enforcement of the reform law is required to be accomplished by the use of so-called intermediate sanctions, whose purpose is to effect change in bad practices of facilities without requiring that they close or that all their Medicaid or Medicare residents move elsewhere. This was the case prior to passage of the law, when the only usable remedy available to federal and state enforcement agencies was to close the facility or withdrawn its certification to receive public money.

The reform law came about after more than twenty years of scandal and resulting public outrage at the poor conditions in nursing homes and the inability of states adequately to address the problem. The history of developing federal involvement is instructive and revealing.

Federal money first became available to nursing homes with the passage of the Social Security Act in 1935. To avoid the development of public poorhouses, Congress prohibited money from going to public institutions, thus stimulating the development of the private nursing home industry. No federal standards existed, however. In 1950, federal law required states to develop programs for licensing nursing homes, but did not prescribe what the licensing standards had to be. By the mid-50s, more than half the money going to nursing homes was public money; but both federal and state governmental commissions were reporting that most nursing homes operated with low standards and poorly trained staff. In the early 1960s, just before the advent of Medicare and Medicaid, Congress found great variations among the states in standards for nursing homes and their enforcement.

When few facilities could meet the standards set by Medicare for participating in that program, the Medicaid program, for low-income people, abandoned reliance on Medicare standards, and left standard-setting to the states. In the late 1960s, federal standards were applied to Medicaid skilled care facilities; however, no such federal standards existed for those Medicaid facilities providing a lower level of care, called intermediate care. Some states avoided federal requirements by reclassifying their facilities as intermediate care facilities. Though federal money supported these facilities, accountability for the use of that money by assuring that the residents received quality care did not exist.

By the 1970s, the nation's nursing homes were receiving billions of dollars of public money, with no uniform standards for quality of care and with no uniform enforcement of those standards that did exist. Deaths caused by fires and food poisoning, as well as other terrible conditions in nursing homes documented in the press, increased pressure on the Congress to examine federal policy intended to protect the frail and vulnerable people who are the residents of such facilities. Still, by the mid-70s, over on-half of the skilled facilities receiving Medicaid money had life safety code problems. Federal oversight was abysmally lacking.

Nursing home residents in Colorado sued the federal government, claiming there was no federal system to protect residents' rights to decent care and treatment. Their lawsuit, together with continued pressures from concerned citizens and policy makers around the country, kept pressure on the government to improve federal standards and monitoring. The same year the lawsuit was filed, a subcommittee of the Senate Committee on Aging issued a report entitled "Nursing Home Care in the United States: Failure in Public Policy."

New federal standards were developed during the late 1970s and were formally proposed in 1980. Only a portion of them – focusing on residents' rights – was published in final form, and that portion was rescinded in 1981 by the Reagan Administration. After public outcry at administration efforts to weaken nursing home

standards, Secretary of HHS Richard Schweiker announced that the Reagan Administration would not "turn back the clock" on protections for nursing home residents. Administration efforts to change the federal survey process to allow greater reliance on private accreditation and on facility self-reporting were similarly met with public opposition and ultimately resulted in Congress negotiating with the administration to fund a study of nursing homes, focusing on standards, surveys and sanctions applied to facilities receiving federal money. The study was undertaken by the Institute of Medicine of the National Academy of Sciences.

The resulting report, "Improving the Quality of Care in Nursing Homes, issued in 1986, served as the blueprint for the federal nursing home reform law, a law that provides the accountability for more than $30 billion of public money that is paid to private nursing homes each year.

The nursing home reform law came into being because of decades of evidence that states lacked standards adequate to protect the vulnerable elderly and disabled residents of nursing homes and did not apply and enforce standards that they had. Repeal or weakening of the reform law, as the National Governors' Association has called for, would undo more than 50 years of effort to assure a decent standard of care for older and disabled citizens.

TIME CHART ILLUSTRATING FEDERAL INVOLVEMENT IN PAYMENTS TO AND REGULATION OF NURSING HOMES

Year or Decade	Activity Related to Nursing Homes
1935	Passage of Social Security Act: federal/state cash assistance to older people could not be used for residents of public institutions. This prohibition stimulated growth of proprietary nursing home industry.
1950	Amendments allow payments in public institutions; also direct payments to providers. States are required to establish licensing programs for nursing homes, but not substantive standards.
1950s	Further federal legislation stimulates private nursing home industry through funds for construction and operation. (Hill-Burton, Small Business and Federal housing administrations)
1950s	Concern is developing about adequacy of state licensing standards and variations in state enforcement, including numbers and qualifications of survey personnel.

1965	Passage of Medicare and Medicaid. Coverage for skilled-type services in nursing homes. Fewer than 15% of facilities could meet life-safety and other quality standards required for Medicare payment. States were left to determine standards for Medicaid payments.
1967	Amendments allow payments to "intermediate care facilities" but with no federal standards.
1970s	Fires and food poisoning deaths, as well as other problems put pressure on federal government for greater oversight. States reclassify facilities from skilled to intermediate because they could not meet standards.
1971	President Nixon announces 8-point plan to improve terrible conditions in nursing homes, including centralizing federal enforcement efforts and increasing federal reimbursement for nursing home inspections.
Year or Decade	**Activity Related to Nursing Homes**
1974	Regulations incorporate intermediate care facilities into Medicaid program. Skilled regulations are weakened. A study issued this year showed the over 50% of skilled facilities were approved with life-safety violations.
1975	Nursing home residents in Colorado sue federal state officials for failure to protect nursing home residents. Senate committee issues a major nursing home report entitled "Nursing Home Care in the United States: Failure in Public Policy."
1970s	Federal government responds to concerns about lack of oversight by developing tools to focus on outcomes. Hearings are held around the country on proposed new regulations.
1980	Proposed new regulations are issued, but most never become final.
Early 1980s	Reagan administration rescinds proposed regulations and begins work deleting many existing standards. Public outcry is so intense, Secretary Schweiker publicly states the administration will not turn back the clock on nursing home residents.

1982-83	Reagan Administration proposes changing the survey process for determining compliance with federal standards. Intense public opposition leads to Congressional moratorium on federal administrative activity. Finally, Congress and the administration agree to a study of the nursing home system to be undertaken by the Institute of Medicine of the National Academy of Sciences.
1986	Institute of Medicine (IOM) issues its report, "Improving the Quality of Care in Nursing Homes" which makes recommendations for standards for nursing homes, for a survey process and for enforcement of standards.
1987	The federal Nursing Home Reform Law, incorporating many of the IOM recommendations, is passed. Its provisions for nursing homes are effective in 1990.

CONGRESSIONAL HEARINGS AND REPORTS LEADING UP TO THE ENACTMENT OF THE NURSING HOME REFORM ACT IN 1987

May 1986: Nursing home care: The unfinished agenda - an information paper.

May 21, 1986: Nursing home agenda: The unfinished agenda, vol. 1.

Feb. 26, 1685: Sustaining quality health care under cost containment.

July 1985: America's elderly at risk.

July 9, 1985: Health care cost containment: Are America's aged protected?

Sept. 10, 1985: The long term care ombudsman program: A decade of service to the institutionalized elderly.

Sept 18, 1985: The rights of America's institutionalized aged: Lost in confinement.

October 1985: Dying with dignity: Difficult times, difficult choices.

October 1, 1984: Discrimination against the poor and disabled in nursing homes.

November 1983: Staff data and materials related to Medicaid and long term care.

February 2, 1982: Medicare coverage and reimbursement of skilled nursing facility services.

March 22, 1982: Long term care for the elderly in Florida.

March 27,1982: Medicaid fraud: A case history in the failure of state enforcement.

July 15, 1982: Nursing home survey and certification assuring quality and care.

July 16, 1982: Nursing home inspections: New Jersey.

December 9, 1981: Oversight of HHS inspector general's effort to combat fraud, waste, and abuse.

May 15, 1980: Medicare and Medicaid fraud.

October 17,1979: Special problems in long-term care.

July 25, 1978: Medicaid anti-fraud programs: The role of state fraud control units.

August 11, 1978: Medicare-Medicaid administrative and reimbursement reform act.

March 1977: Fraud and abuse in nursing homes: Pharmaceutical kickback arrangements.

June 8, 1977: The national crisis in adult care homes.

June 17, 22, 23, 30 and July 1, 1977: Civil rights of institutionalized people.

June 30, 1977: Kickbacks among Medicaid providers.

March 1976: Nursing home care in the United States: Failure in public policy.

June 3, 1976: The tragedy of nursing home fires: The need for a national commitment for safety.

August 1976: Fraud and abuse among practitioners participating in the Medicaid program.

September 1976: The tragedy of multiple death nursing home fires The need for a national committment to safety.

January 1975: Nursing home care in the United States: Failure in public policy.

February 1975: Nursing home care in the United States: Failure in public policy.

August 1975: Nursing home care in the United States: Failure in public policy.

September 1975: Nursing home care in the United States: Failure in public policy.

September 26, 1975: Medicare and Medicaid fraud.

November 11, 1975: Society's responsibilities to the elderly.

November 13, 1975: Medicare and Medicaid fraud.

December 5, 1975: Medicare and Medicaid fraud.

December, 1974: Nursing home care in the United States: Failure in public policy - an introductory report.

December 1974: The litany of nursing home abuses and an examination of the roots and controversy, supporting paper #I.

February 11, 1965: Conditions and problems in the nation's nursing homes, part-1.

February 15, 1965: Conditions and problems in the nation's nursing homes, part-2.

February 17, 1965: Conditions and problems in the nation's nursing homes, part-3.

February 23, 1965: Conditions and problems in the nation's nursing homes, part-4.

August 9, 1965: Conditions and problems in the nation's nursing homes, part-6.

August 13, 1965: Conditions and problems in the nation's nursing homes, part-7.

May 5, 1964: Nursing homes and related long term care services, part-1.

May 7, 1964: Nursing homes and related long term care services, part-3.

For a listing of Congressional hearing and reports related to nursing home care since 1987 and/or for a listing of state and national reports on nursing home care, please contact The National Citizens' Coalition for Nursing Home Reform.

EDITORIALS

"Let the people know the facts and the country will be saved."
ABRAHAM LINCOLN

Existing protections

The Republican Congress has taken steps to eliminate burdensome federal regulations, many of which are unnecessary and costly to individuals and businesses.

But when it comes to abolishing nursing home regulations, which protect the health and safety of elderly citizens, some caution is to order.

Before repealing a law that has vastly improved conditions at nursing homes in Indiana and nationwide, lawmakers should study the sordid history that led to its enactment. They are likely to find this is one area where uniform federal standards make sense.

At issue is the Nursing Home Reform Act of 1987, the final phase of which took effect just this past July. As part of the move to turn Medicaid into block grants for the states, Congress is trying to repeal the law and drastically reduce funding of the nursing home enforcement system.

The nursing home law is one area where uniform federal standards make sense.

The 1987 law — which requires nursing homes that receive Medicaid dollars to follow good nursing practices and protect residents' rights — was the result of years of study, public hearings and documentation of abuses, such as the use of unnecessary physical restraints and excessive reliance on drugs for behavior control.

The standards have been gradually phased into effect over the past eight years. As of July 1, agencies such as the Indiana State Department of Health have federal authority to levy fines and ban admissions at homes that violate the standards. As recent experience has shown, the law has dramatically changed how officials police bad facilities.

For example: During the entire 11-year period from 1984 to 1995, Indiana assessed only 33 fines against nursing homes for violating regulations. In the three months since July 1, 28 state fines have been levied, three homes barred from accepting new residents pending resolution of problems and four homes scrutinized by state monitors inside their facilities. In addition, the federal government denied Medicaid to 12 homes and issued 48 civil financial penalties.

If the proposed legislation passes, it is highly unlikely states will replicate the federal law. In fact, they will be under intense pressure from the nursing home industry to deregulate facilities to compensate for Medicaid reimbursement cuts. Beds for those who depend on Medicaid will become scarce since long waiting lists are already common.

Scott Severns, an Indianapolis attorney and president of the National Citizens' Coalition for Nursing Home Reform, believes federal rules may actually save taxpayers' money spent on the elderly. As a result of the '87 law, he notes, hospitalizations of nursing home residents have dropped 25 percent, which means less spent through Medicare.

"Nursing home residents who are hospitalized for broken bones, bedsores and infections from neglect cost far more than residents who receive proper care," he says.

If Congress wants a compelling reason to preserve the federal protections, it need look no further than Ritter Health Care Center in Indianapolis.

Last month, state inspectors found Ritter residents tied with gauze to rails and beds and smeared with food and body wastes. Some were confined to rooms by greased door handles because too few staff were available to supervise. One resident on a liquid diet choked on a piece of food.

Ritter had been cited for numerous violations since 1993, but never really punished. Thanks to the new federal tools, the health department moved swiftly this time. The owners have been fined and denied Medicaid eligibility. Tragically, residents must now move elsewhere because of the facility's failure to correct its problems.

That is how the federal law was designed to work. That is how it is working in Indiana. At this point, it would be a mistake to repeal what isn't broken.

EXHIBIT B

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THE

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—Allen H. Neuharth
Founder, Sept. 15, 1982

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Today's debate: REGULATING NURSING HOMES

Dropping federal regs is an invitation to tragedy

OUR VIEW **Everyone has heard the horror stories about the bad old days in nursing homes. Why go back to them?**

Eight years ago, after 15 years of argument, Republicans and Democrats in Congress got together to correct a public embarrassment. They passed a law to stop nursing home operators from abusing or neglecting the elderly.

They had ample incentive. Reports of residents lying in excrement, dehydrated, malnourished or overmedicated were commonplace. State regulation was a failure. Public outrage was high.

It should be just as high now. The regulations created by that law are about to be weakened or stripped away — victims of an ideological crusade to curb federal authority, good or bad.

Control would return to the states, despite their history of failure.

Those pushing the new plan, House and Senate Republicans, claim their legislation is not a repeal. They say the law is ineffective. And they say it's hugely expensive.

All three claims are fiction.

Not a repeal? Under existing regulations violators are subject to financial penalties, decertification, denial of payments or takeover by temporary managers if they violate health and safety standards. Proposed changes would weaken enforcement by states that are vulnerable to powerful lobby groups. The Senate wouldn't require inspections, nurse staffing or protections against restraints or medication.

Not effective? A government study of 269 homes in 10 states cited impressive results. The study found hospitalization of nursing home residents down 25%, use of restraints down 25%, and detection and punishment of abuses increasing.

Too expensive? Quite the contrary. A study of 9,000 Georgia nursing-home residents reports a monthly $76,738 savings by curtailing unnecessary drug therapy, thanks to the regulations. And that's not an isolated case. The National Citizens' Coalition for Nursing Home Reform, a resident advocacy group, says the changes saved billions in costs attributed to poor treatment.

Even the American Health Care Association, representing nursing home owners, says costs have not been a problem.

In fact, nursing home owners signed onto the legislation when it passed in 1987. So did consumer groups. So did state officials. So did the Institute of Medicine, research arm of the National Academy of Sciences, whose 1986 report on nursing home conditions led to the reform.

No credible evidence exists to justify reversing course. If changes are necessary they should be based on the same kind of thorough study and public hearings that produced the original regulations.

Seniors are in nursing homes because of advanced age, mental or physical disabilities, to recover from hospitalization or because they have no one to care for them. They are frail and vulnerable. They deserve all the protection the public can provide.

Distributed by the National Citizens' Coalition for Nursing Home Reform

The New York Times

Founded in 1851

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Keep Nursing Home Standards

In its ongoing effort to give more power to the states, Congress wants to scrap Federal standards for quality of care in nursing homes. Given past abuses that the standards were designed to guard against, and the future need for even more nursing homes, this is an invitation to trouble. There may well be room to revise the Federal standards to make them simpler and less costly. But with vast changes occurring in the health-care system, the need for Federal standards to insure minimal quality is greater than ever.

It was only about 20 years ago that a series of media exposés, state government reports and legislative hearings revealed widespread abuses in nursing homes, from unsanitary conditions and malnutrition to overmedication, neglect and sexual and physical abuse. In 1987 Congress passed the Nursing Home Reform Act, which set national standards for staff training, individual assessments of patients and protection of basic patient rights, including the right not to be physically restrained, the right to voice grievances and the right to be notified before transfer or discharge.

The law has begun to make a difference. In the mid-1980's, about 40 percent of nursing home patients were physically restrained; now, less than 20 percent are. Improved care has also led to savings on medications and unnecessary hospitalizations.

Now Congress is trying to reshape the health-care system by sharply cutting Medicaid, which provides about 60 percent of nursing home funding, and shifting the money to state control through block grants. Congress wants to cut $182 billion out of Medicaid over seven years, which would likely lead to reduced reimbursement rates for nursing home services and facilities.

Many states are insisting that, if they are to assume control of a reduced pot of money, they must have the power to set their own nursing home standards to eliminate needless costs. House and Senate committees have separately passed bills that would give states primary responsibility for setting quality-of-care standards for nursing homes, with Washington offering only general categories to be covered. Nursing home providers could lean on states to cut back on standards that they will not be able to live up to for lack of funds.

Nearly two million people now reside in nursing homes. But with an estimated 43 percent of people over 65 years of age likely to spend some time in a nursing home, and an aging baby-boomer population, the demand for these facilities will only grow. To abandon national standards now may invite a return to the nursing home disasters of the past.

EXHIBIT D

The CHAIRMAN. Thank you very much, Mr. Severns.
Mr. Willis.

STATEMENT OF JOHN WILLIS, PRESIDENT, NATIONAL ASSOCIATION OF STATE OMBUDSMAN PROGRAM AND TEXAS LONG-TERM CARE OMBUDSMAN, AUSTIN, TX

Mr. WILLIS. Good morning, Senator Cohen and Senator Pryor. I'm John F. Willis, State Ombudsman for the State of Texas and president of the National Association of State Ombudsman Programs. Thank you for this opportunity to comment on the nursing home provisions of OBRA.

The NASOP, National Association of State Ombudsman Programs, represents the 52 State and territorial ombudsman programs in this country. Our organization and programs are not a regulatory agency but rather an advocacy group. Thirty-four of these States use the talents of specially trained and certified volunteers who regularly go into nursing homes. My perspective today is to talk about how OBRA has worked to the benefit of these residents, and I would be remiss if I didn't also say that through the efforts of the Administration on Aging and our ombudsman programs in five States, have now begun partnership with the Operation Restore Trust effort, with HCFA, and the Administration on Aging. I will tell you from a budget perspective just what I've learned so far in these few months. Our health care system can save billions of dollars just by eliminating fraud waste and abuse, and I think that holds promise for the benefit of the system.

Let me skim through my testimony. I will not talk about the history, I will not talk about the provisions, but let me simply say that OBRA 87 has worked and is benefiting residents throughout this country. The use of psychotropic drugs and other mind-altering chemicals has declined approximately 30 percent. The Health Care Financing Administration reports that most States are reporting decreases of between 20 and 40 percent in use of restraints. Residents who are physically restrained require more nursing home care than their unrestrained counterparts. The results of a restraint-free environment, which has been said already, is to reduce cost in hospitalization and other medical interventions.

Skin break down is not a normal condition for frail, older people. Skin breaks down and pressure ulcers occur most often when basic needs such as food, fluid, cleanliness, and mobility are not provided. Federal nursing home standards provide a structure to prevent these from occurring. OBRA 87 requires 24-hour license nursing service and training of nurse aides.

In my own State of Texas we've gone from staffing situation where there will be one LV in on a 24-hour period, to a RN during the day shift and at least one LVN on each of the other shifts. We've also gone from a meager 16-hour orientation for nurse aides to a well developed 75-hour curriculum with competency testing. These higher standards have resulted in better care for residents as a whole.

The Nursing Home Reform Act must not be repealed. OBRA 87 has been an evolution of positive actions. The recent implementation, July 1 to the Federal enforcement standards was the last act mandated under these Federal requirements. The enforcement

process is necessary, although not a perfect system, and we're confident that the Health Care Financing Administration will be able to modify this, to make it truly work for the residents in this system.

Our system of care in this country is not perfect. Even with the predictable nature of the nursing home regulations, poor care will be delivered.

I want to share with you three examples from the State of Texas that illustrate these:

Three days ago relatives of a 100-year woman who died in a nursing home received an out-of-court settlement for $3.2 billion in a wrongful death suit against a national chain. The lawsuit claimed that the nurse aide either intentionally or accidentally abused the nursing home resident that resulted in the resident's death. The nurse aide had been fired from at least one nursing home job for patient neglect and had received no training in the other facility.

Although it requires training of at least 75 hours and competency testing, had this nurse aide been properly trained, it is possible these injuries would have been avoided and the resident's life preserved. Had earlier reports of allegations of abuse been properly recorded and documented, this aide would not have been a candidate of employment at the second facility.

The Nursing Home Reform Act attempts to give nursing home resident as much control over their own lives as possible. Inadequate and inconsistent State supervision has been one of the reasons the Federal law was put in the first place. Nursing home standards should be understandable, consistent, and predictable from State to State.

Another case involving an 82-year-old female who was admitted to a nursing facility following unsuccessful efforts by the family to provide home care. The resident enjoyed good care and was realizing improvements to her medical condition when the family was told it would be necessary to transfer her to another facility. The facility staff indicated that, quote, "It was not possible to meet her needs in that facility."

This verbal transfer notice was based on the actions of family members and the fact that two family members were quarreling over the priorities for care for this resident. The facility's response to this family dispute was to discharge her from the facility.

OBRA 87 strengthened transfer and discharge rights and set out a precise method of notification and justification. When challenged by the ombudsman program to produce a written notice, the facility withdrew its request and did not move the resident.

Today that resident enjoys good care and the family issues are being handled as a separate issue, apart from resident care environment. Under OBRA residents rights are consistent from State to State, are easily understood and easily accessible.

A third and last case—an 80-year-old female nursing home resident had been admitted to the facility and was awaiting for Medicaid certification. The resident had been on medication prior to her admission but was required to change physicians because her primary care physician did not serve residents in that nursing facility. A new doctor took her off all medications. The resident became dis-

oriented, exhibited cognitive disorder, and when the resident was reviewed for Medicaid status, there was no indication that she needed medication, or assistance of any kind, and our request for Medicaid was denied.

The care plan and assessment by this resident did not indicate the change in her condition and the fact that she now needed assistance with eating and dressing. When challenged, the facility conducted a new assessment, developed an appropriate care plan and the resident today is enjoying both Medicaid certification, as well as appropriate care in that facility.

Assessments, care plans and the appeal process are all major provisions of the Nursing Home Reform Act that have had a positive impact on care.

Senator Cohen and Senator Pryor, nursing home residents depend on the provisions of OBRA 87, and they should not be left in a situation where they are not protected by these guidelines and these standards. Frail and vulnerable nursing home residents should not have to pay the price of poor care so this country can balance its budget. Our Association urges your support to include the provisions of the Nursing Home Reform Act as requirements to the States and any consideration of block granting the Medicaid program.

Thank you again for this opportunity and our Association stands ready to assist you in your advocacy for older Americans.

[The prepared statement of Mr. Willis follows:]

PREPARED STATEMENT OF JOHN F. WILLIS

Good morning Mr. Chairman and members. I am John F. Willis, president of the National Association of State Long-Term Care Ombudsman Programs and also serve as State Ombudsman for the Texas Department on Aging in Austin, Texas. Thank you for this opportunity to provide testimony on behalf of NAGOP regarding the effects of Federal nursing home standards on quality of care and quality of life. The National Association of State Ombudsman Programs represents the 52 State ombudsman programs operating under the provisions of the Older Americans Act. The ombudsman program advocates for a high quality of life and care for nursing home residents. Our program is not a regulatory program, but rather an advocacy program that in most States uses the talents of specially trained and certified volunteers to help residents and their families understand their rights and know how to access needed benefits and services. The program receives and investigates complaints by or on behalf of nursing home residents, but is also is responsible to educate consumers, policy makers, and the public on the needs of long-term care residents.

I should also add that through the initiatives of the Administration on Aging the ombudsman program in 5 pilot States have begun a cooperative program with the Health and Human Services Inspector General and Health Care Financing Administration to combat fraud, waste and abuse in the health care system. The ombudsman program along with the aging network are partners in Operation Restore Trust and believe significant savings will be realized as a result of this effort.

Congress passed the National Nursing Home Reform Act in 1987, following over 15 years of work by consumers, health care professionals, and providers nationwide. The landmark legislation enjoyed bi-partisan support and promised for the first time in the history of regulation, a consistent and predictable system of quality care for this country's 1.9 million nursing home residents. Much or today's regulation can be traced to the congressionally initiated 1983 Institute of Medicine study that recommended a national public policy for nursing homes as a sound and necessary approach to protecting resident's safety and well being. The final provisions of the Nursing Home Reform Act (OBRA 1987) have only been implemented this year.

The Institute of Medicine study found "shockingly deficient care" in some nursing homes and concluded that "a stronger Federal role is essential." Congress responded in 1987 by passing a law that specifies what nursing homes must do to protect patient's rights and to enhance "the quality of life of each resident."

The key elements of the "resident centered" Nursing Home Reform Act include:

- Individualized assessment of each resident's abilities and needs.
- A plan of care, with specific goals, methods and measurements addressing each resident's needs.
- Requirement for 24-hour licensed nursing service.
- A standard of care that supports the physical, mental and psychosocial wellbeing of each resident through supportive care, therapy, and resident and family participation.
- A standard for quality of life for each resident that provides reasonable accommodation of individual needs and preferences.
- Protection of resident's rights to dignity and security, and freedom from abuse, restraints, and involuntary transfers and discharges.
- Training and testing for nurse aides, who deliver the majority of the care to residents.
- Employment of a full-time social worker for larger facilities.
- Enforcement of standards through effective survey procedures that review the care from the resident's point of view, identify problems, assure correction and apply appropriate penalties and sanctions.

The Nursing Home Reform Act provides a framework for nursing facilities to help each resident reach his or her "highest practicable physical, mental, and psychosocial well-being." It also requires services to be performed "in a manner and in such an environment as will promote maintenance of quality of life with reasonable accommodation for individual needs and preferences." This simply means that nursing homes have to consider the individual resident and the care planning must be resident centered. For the first time in history, the evaluation of care is based on the outcome of care from the resident's perspective, not simply from the standpoint of what the facility was required to do.

OBRA 87 has worked! And is benefiting residents throughout this country. The use of psychotropic drugs and other mind altering chemicals has declined approximately 30 percent. The Health Care Financing Administration reports that most States are reporting a decrease of 20–40 percent in the use of restraints. Residents who are physically restrained require more nursing care than their unrestrained counterparts. The outcome of restraint free care in residents who are alert and more independent, less prone to drug-induced falls, skin ulcers, and contractures that often require more costly medical care. Not only have these regulations resulted in a higher quality of care and a higher quality of life, but also substantial savings to this nation by preventing costly medical interventions.

Skin break down is not normal for frail older people. Skin break down and pressure ulcers occur most often when basic needs such as food, fluid, cleanliness, and mobility are not provided. Federal nursing home standards provide a structure to prevent these from occurring. OBRA 87 requires 24-hour licensed nursing services and training of nurse aides. In my own State of Texas, we have gone from staffing situations where there might be one licensed vocational nurse (LVN) working in a 24-hour period to an RN on the day shift and an LVN on the other shifts. We have also gone from a meager 16-hour orientation for nurse aides to a well-developed 75-hour curriculum with competency testing. These higher standards have resulted in better care for residents as a whole.

The Nursing Home Reform Act must not be repealed. OBRA 87 has been an evolution of positive actions. The recent implementation, July 1, 1995, of the Federal enforcement system was the last act mandated under these Federal requirements. The enforcement process is necessary, although is not a perfect system. These last three months have pointed out many areas for improvement and we are confident that the Health Care Financing Administration will streamline the enforcement provisions and that they will work for the benefit for residents.

Our system of care in this country is not perfect. Even with the predictable nature of the nursing home regulations, poor care will be delivered. Recent examples brought to my attention illustrate the need for strong, clear and enforceable nursing home standards:

Three days ago relatives of a 100-year-old woman who died in a nursing home received an out of court settlement of $3.2 million in a wrongful death suit against a national chain. The lawsuit claimed that a nurse aide either intentionally or accidentally abused a nursing home resident that resulted in the resident's death. The nurse aide had been fired from at least one nursing home job for patient neglect and had received no training. OBRA requires training of at least 75 hours and competency testing. Had this nurse aide been properly trained, it is possible these injuries would have been avoided, and the residents's life preserved. Had earlier reports and allegations of abuse been properly recorded and documented, this aide would

not have been a candidate for employment at that facility. The Nursing Home Reform Act attempts to give nursing home residents as much control over there own lives as possible. Inadequate or inconsistent state supervision had been one of the reasons for this national law in the first place. Nursing home standards should be understandable, consistent and predictable from State to State.

An 82-year-old female was admitted to a nursing facility following unsuccessful efforts by the family to provide home care for her. The resident enjoyed good care and was realizing improvements to her medical condition when the family was told it would be necessary to transfer her to another facility. The facility staff indicated that "it was not possible to meet her needs" in that facility. This verbal transfer notice was based on the actions of family members and the fact that two family members were quarreling over the priorities of care for the resident. The facility's response to this in-family dispute was to discharge her from the facility. OBRA 87 strengthened transfer and discharge rights and set out a precise method of notification and justification. When challenged by the ombudsman program to produce a written notice, the facility withdrew its request to move the resident. Today that resident enjoys good care, and the family issues are being handled as a separate issue, apart from the resident care environment. Under OBRA, residents' rights are consistent from State to State, are easily understood and readily accessible.

An 80-year-old female nursing home resident had been admitted to the facility and was awaiting Medicaid certification. The resident had been on medication prior to her admission but was required to change physicians because her primary care physician did not serve residents in nursing facilities. Her new doctor took her off all medications. The resident because disoriented and exhibited cognitive disorder. When the resident was reviewed for Medicaid status, there was no indication she needed medication or assistance of any kind, and her request for Medicaid was denied. The care plan and assessment for this resident did not indicate the change in her condition and the fact she now needed assistance with eating and dressing. When challenged, the facility conducted a new assessment and developed an appropriate care plan. The resident received Medicaid certification and is receiving appropriate and predictable care today.

Assessments, care plans and the appeal process are all major provisions of the Nursing Home Reform Act that have a positive impact on care.

Mr. Chairman and members of the Committee, nursing home residents depend on the protections provided by the Nursing Home Reform Act. These uniform Federal standards uphold quality of care. Frail and vulnerable nursing home residents should not have to pay the price of poor care so this country can balance its budget. Our association urges your support to include the provisions of the Nursing Home Reform Act as a requirement to the States in any considerations of block granting the Medicaid program.

Thank you again for the opportunity to discuss these very important issues. Our association stands ready to assist you in preserving the dignity and quality of life for elderly Americans.

The CHAIRMAN. Thank you very much Mr. Willis.

Ms. Reap.

STATEMENT OF ELLEN REAP, PRESIDENT, ASSOCIATION OF HEALTH FACILITY SURVEY AGENCIES, WILMINGTON, DE

Ms. REAP. Thank you, Mr. Chairman, Senator Pryor.

I am Ellen Reap, and I am president of the Association of Health Facility Survey Agencies and director of the Office of Health Facilities Licensing and Certification in the State of Delaware.

AHFSA is made up of the State survey and certification agencies that regulate nursing homes, hospitals, intermediate care facilities for the mentally retarded, home health agencies, renal dialysis facilities, hospices and a wide array of other health care services based on various State and Federal laws and regulations.

The members of AHFSA are the quality assurance arm of the Medicaid and Medicare programs. We conduct the onsite, comprehensive inspections of health care services provided by over 148,000 health care institutions and programs. Under agreements with HCFA, our State agencies inspect and regulate more than

27,670 facilities containing over two million beds, and the programs and services of over 120,000 providers.

Over half of our total effort nationwide involves nursing homes that are participating in the Medicaid or Medicare programs. We are not HCFA bureaucrats or lobbyists. We work every day with nursing home residents, administrators, ombudsman and people with complaints or concerns about nursing homes.

The State survey agencies are the people in the States with the best actual experience with, and knowledge of, the nursing home quality standards. One of the things we do know about the Federal nursing home standards is that they are a real value to us in the States in trying to improve the quality of care in nursing home. We know, from our own experience, the positive impacts these regulations have had on the way people are treated in nursing homes, both as human beings and as residents.

The nursing home regulations are not typical Federal paperwork requirements, as some critics have portrayed them. The key nursing home regulation is at 42 CFR Part 4, 83 subpart B. The proposals of both the Senate Finance Committee and the House Ways and Means Committee make dramatic changes to these regulations. In neither bill are there any quality of care provisions, which are the core requirements governing the actual care the residents receive. These requirements under the current standards require that facilities take steps to ensure that residents remain able to bathe and groom themselves, to walk or get around independently, to toilet themselves, to eat and to communicate. These are the regulations that prevent nursing homes from taking someone's mother who has become unsteady on her feet but is fully continent and leaving her in a diaper in a wheelchair where she permanently loses control of her bladder, the ability to walk and her sense of dignity.

The quality of care regulations being eliminated also require that nursing homes prevent pressure sores. Pressure sores are not an inevitable result of age and institutionalization. With good nutrition, skin care, proper positioning, and staff attention, these ulcers can be kept from destroying the skin, bones and comfort of nursing home residents. It is also much less expensive to prevent pressure sores than to treat them after they have become serious medical problems.

These quality of care provisions being eliminated also require that residents who can eat normally, either independently or with assistance, not be subjected to feeding by naso-gastric tube. It may take more staff to help residents maintain normal eating skills, but by doing so we reduce the incidents of aspiration pneumonia, vomiting, diarrhea, metabolic abnormalities, and nasal ulcers. We also help to maintain the senior's dignity and ability to talk.

The quality of care regulations being eliminated also require that unnecessary antipsychotic drugs not be administered unless medically necessary. This requirement prevents nursing home residents from spending their final years in a needless stupor. The current quality of care regulations do not cover controversial policy questions. There should be no public policy debate that a facility being paid to care for someone should be required to take reasonable efforts to ensure that a resident does not develop pressure sores.

The proposals before the Senate Finance Committee and the House Ways and Means Committee also eliminate the quality of life regulations. A recent study by Abt Associates found that these regulations cover the areas most important to nursing home residents. The regulations require that residents be allowed to make choices in their activities, schedule and health care; that residents be able to participate freely in resident and family groups; that residents can participate in religious activities; and that the facility make reasonable accommodation of each person's needs and preferences.

The proposals of both the Senate Finance Committee and the House Ways and Means Committee also dilute sections of the regulations dealing with resident rights. The current regulations do not establish any unreasonable rights for residents but only those every American citizen expects from any health care facility.

Both of the bills eliminate the important right to be free from restraint, and both bills allow residents to be transferred or discharged from the facility without any reason. They also eliminate the requirement that facilities have sufficient staff to provide needed care. Both bills eliminate the requirement that nursing homes meet the life safety code requirements. Most amazingly, both bills eliminate the requirement that nursing homes employ any registered or licensed nurses, that nurses aides employed by nursing homes be trained and competent to care for the elderly and that physicians supervise the health care provided.

Do we really want to save money on our nursing homes by staffing them with amateurs rather than health care professionals?

These are also not necessary regulations——

The CHAIRMAN. Ms. Reap, your statement is pretty long, and it will be included in full, but if you could just get to the highlights of it so we can ask you a few questions.

Ms. REAP. OK, thank you.

There is not a single one of these regulations, though, that I have not seen violated by nursing homes, and I would like to say that the nursing homes that violate these regulations are not typically setting out to do anything wrong to the residents. They usually violate this section because providing good care all of the time is a hard job, and it is easy for facilities to slip into poor practices.

The part that my office and the other State agencies play in nursing home quality is that we will help the facility see where they have developed hopefully before those problems have become serious and residents start to die. Eliminating these regulations will not save anyone any money in the long run. There is no public policy position that we should save money by tying people up rather than having adequate staff to care for them. There is no public policy issue that States are anxious to address, or money any of us want to save, by leaving seniors sitting for hours in their own excrement. There is no public policy issue that should lead us back to the days when twice as many nursing homes residents suffered dehydration as they do today.

I contacted, in preparing to speak to you today, approximately 20 of my counterparts across the country for their thoughts on what the States would do in terms of regulations to replace the Federal standards. Most States expect this effort to be severely limited by

funding, and several States quite clearly felt that they would adopt bare minimum standards. Only one State told me they plan to adopt the Federal standards largely intact. It's clear that the various States would adopt various standards. These differences from State to State would undoubtedly grow with time, as would the ways in which the different regulatory and judicial bodies would interpret those regulations.

We will, within a few years, have 50 unique and distinct sets of regulations governing nursing homes, and 50 unique and distinct survey protocols and systems, assuming that all States maintain some level of inspection. And transfer of the regulatory process would generate additional administrative costs to the State, such as developing standards, developing the survey tools, the software, the protocol and processes, developing the training programs for the surveyors and the providers, developing the interpretative guidelines, the hearing processes, defending the regulations against legal challenges, fielding new forms and countless other tasks. And it's important to note that each of these cost elements will be borne separately by each of the 50 States.

These costs will come to the States concurrently with the greater State burden anticipated under the proposals. The State survey agencies will be placed in the unenviable position of needing a larger share of State health care funds as we transition into the process of State regulation.

I expect that the revocation of the Federal nursing home standards, in that it will place the entire survey and certification burden on the States will lead to a reduction in funding for this activity that will cause a substantial weakening of the inspection programs of many States, and I know from my experience in traveling across the country that there is a direct correlation between the States maintaining an effective inspection program and the quality of those nursing homes in that State. I, therefore, believe that this action will ultimately lead to a deterioration in the quality of nursing homes.

My written testimony also addresses some specific concerns we have with the provisions of the Chairman's mark limiting the State's flexibility and enforcement, and also a serious cut in the fiscal year 1996 survey program funding proposed by the Senate Appropriations Committee, and I would urge you to consider those issues.

I am grateful to have been given the chance to speak to you today, and want to close by urging you not to let the citizens of States return to the days where our spouses, our mothers, friends, fellow citizens could be warehoused in nursing homes waiting to die. I never want again to visit a nursing home and see people who could still enjoy their lives demeaned or degraded by being tied to chairs, left in diapers. And I especially do not want to return to the days where I could see that and be powerless to change it.

[The prepared statement of Ms. Reap follows:]

ASSOCIATION OF HEALTH FACILITY SURVEY AGENCIES

TESTIMONY OF

ELLEN T. REAP, PRESIDENT
ASSOCIATION OF HEALTH FACILITY SURVEY AGENCIES

BEFORE THE

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

October 26, 1995

Mr. Chairman, members of the committee, I am Ellen Reap. I am President of the Association of Health Facility Survey Agencies (AHFSA) and Director of the Office of Health Facilities Licensing and Certification in the State of Delaware which is Delaware's state survey and certification agency. It is an honor to be here and to have the opportunity to present my views on the various proposals to eliminate or greatly modify the current federal nursing home quality standards.

AHFSA was established in 1968 as a not for profit organization to provide a forum for health care regulatory agency directors and managers to address common interests, concerns, and health care program issues. AHFSA actively participates with the U.S. Department of Health and Human Services, the Health Care Financing Administration, providers, and advocacy groups in planning, implementing, and assessing the effectiveness of health care programs.

AHFSA is made up of the state survey and certification agencies that regulate nursing homes, hospitals, medical laboratories, intermediate care facilities for the mentally retarded, home health agencies, hospices, rural health clinics, renal dialysis centers, ambulatory surgical centers, rehabilitative services, nurse aide training programs, and a wide array of other health care services based on various state and federal laws and regulations.

The members of AHFSA are the quality assurance arm of the Medicare and Medicaid programs. Our members conduct on-site, comprehensive inspections of health care institutions and programs to determine compliance with the federal and state requirements and investigate complaints of abuse or neglect of individuals and of poor care by health care providers.

Our member agencies in the fifty states oversee the health care services provided by over 148,000 health care institutions and programs. Under agreements with HCFA under the Medicare and Medicaid programs, our state agencies inspect and regulate more than 27,670 facilities containing over 2,000,000 beds and the programs and services of over 120,000 providers.

AHFSA members employ a professional staff of over 6,000 for inspecting and regulating the Medicare and Medicaid providers at a total cost of less than one percent of the total payments made on behalf of beneficiaries.

Over half of our total effort nationwide involves nursing homes participating in the Medicare or Medicaid programs. We are not HCFA bureaucrats or lobbyists. In fact, AHFSA has no staff and no Washington office. We are the people out there in nursing homes every day, examining care plans, assessing nutrition, looking at restraint reduction, and talking to residents. We talk every day with nursing home administrators, ombudsmen, and people with complaints or concerns about nursing homes. The reason this information is important is that the state survey agencies are the people in the states with the best actual experience with and knowledge of the nursing home quality standards.

One of the things we know about the federal nursing home standards is that they are of real value to us in the states in trying to improve the quality of care in nursing homes. We know from our own experience the positive impact these regulations have had on the way people are treated in nursing homes both as human beings and as residents. We also believe these are good reasons to keep these regulations in effect.

As you know, the current nursing home regulations have their impetus in the Omnibus Budget Reconciliation Act of 1987 and were implemented by the Congress because of poor quality of care in nursing homes in many parts of the country. I know that the overwhelming majority of nursing home owners, administrators and staff have a genuine interest in the quality of life, the quality of care, and the well being of nursing home residents. I know that prior to the OBRA 87 regulations the great majority of those same people had similar good intentions. Nevertheless, despite the good intentions of everyone, due to the inaction of both federal and state regulators, a great many nursing homes before OBRA 87 did little more than warehouse people keeping them comfortable until they died. Dr. Hawes was a member of the Institute of Medicine Committee that helped to develop the requirements of OBRA 87 so I will certainly defer to her superior expertise in putting the current regulations into their proper historical context.

Over the past several weeks, I have had the opportunity to follow the discussions via C-SPAN on some of the proposed changes to the Medicare and Medicaid programs. I have listened to a great many discussions on reimbursement, block grants, new types of provider organizations, and capitation rates. One of the issues I have heard discussed very little is the QUALITY of care provided in our nursing homes.

The nursing home regulations are not typical federal paperwork requirements as some critics have portrayed them. The key nursing home regulation is at 42 CFR Part 483 Subpart B. The proposals of both the Senate Finance Committee and the House Ways and Means Committee make dramatic changes to these regulations. In neither bill are there any Quality

of Care provisions which are the core requirements governing the actual care the residents receive. These requirements in the current standards require that facilities take steps to ensure that residents remain able to bathe and groom themselves, to walk or get around independently, to toilet themselves, to eat and to communicate. These are the regulations that prevent nursing homes from taking someone's mother who has become unsteady on her feet but is fully continent and leaving her in a diaper in a wheelchair where she permanently loses control of her bladder, the ability to walk, and her sense of dignity. The Quality of Care regulations being eliminated also require that nursing homes prevent pressure sores. Pressure sores are not an inevitable result of age and institutionalization. With good nutrition, good skin care, proper positioning and staff attention, the ulcers can be kept from destroying the skin, bones, and comfort of nursing home residents. It is also much less expensive to prevent pressure sores than to treat them after they have become serious medical problems. These Quality of Care provisions being eliminated also require that residents who can eat normally either independently or with assistance not be subjected to feeding by naso-gastric tube. It may take more staff to help residents maintain normal eating skills but by doing so we reduce the incidence of aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. We also help to maintain the senior's dignity and ability to talk. The Quality of Care regulations being eliminated also require that unnecessary drugs and antipsychotic drugs not be administered unless medically necessary. This requirement prevents nursing home residents from spending their final years in a needless stupor. The Quality of Care regulations being eliminated require that residents receive proper nutrition and hydration, that their vision and hearing needs are met, and that the nursing homes provide care for residents' special medical needs, such as tracheostomy care. The current Quality of Care regulations do not cover controversial policy questions. There should be no public policy debate that a facility being paid to care for someone should be required to make some reasonable efforts to ensure that a resident does not develop pressure sores.

The proposals of both the Senate Finance Committee and the House Ways and Means Committee also eliminate the Quality of Life regulations. A recent study by Abt Associates found that these regulations covered the areas most important to nursing home residents. This regulation requires that the facility provide care for residents in a way that promotes the dignity of the resident. The regulations require: that residents be allowed to make choices in their activities, schedule and health care; that residents can participate freely in resident and family groups; that residents can participate in religious activities; and that the facility makes reasonable accommodation of each individual's needs and preferences. The Quality of Life regulation being eliminated also requires that the facilities provide a clean and comfortable

environment where the resident can use his or her personal belongings to the extent possible.

The proposals of both the Senate Finance Committee and the House Ways and Means Committee also dilute sections of the regulations dealing with resident rights. The current regulation does not establish any unreasonable rights for residents but only those every American citizen expects from any health care facility — that residents can exercise their rights without reprisal; that residents get information they need to stay in control of their lives and health care to the extent they are able; that they can control their own funds if they wish and, if they have the facility handle this, the facility has to be accountable for the funds; the right to choose their own physician and participate in planning their own care; the right to privacy and confidentiality; the right to voice grievances; the right to look at survey results and to talk with client advocates; the right to work or to not work in the facility; the right to receive mail; the right to have visitors and the right to have access to state and federal agencies; the right to reasonable access to the phone with some privacy; the right to maintain and use their personal possessions; the right to share a room with their spouse; the right to take care of yourself if it is safe to do so; and the right to refuse to be transferred to other rooms in the facility in certain conditions. Both of these bills eliminate the important right to be free from restraint and both bills allow residents to be transferred or discharged from the facility without any reason.

The Senate Finance Committee's Chairman's Mark eliminates the requirement that facilities have sufficient staff to provide needed care. Both bills eliminate the requirement that nursing homes meet the Life Safety Code requirements of the National Fire Protection Association. Most amazingly, both bills eliminate the requirements that nursing homes employ any registered or licensed nurses, that nurse's aides employed by nursing homes be trained and found competent to care for the elderly, and that physicians supervise the health care provided. Do we really want to save money on our nursing homes by staffing them with amateurs rather than health care professionals?

These are also not unnecessary regulations: there is not a single one of these regulations that I have not seen violated by nursing homes. The nursing homes that violate these regulations are not typically setting out to do anything wrong to the residents. They usually violate this section because providing good care all the time is a hard job and it is easy for facilities to slip into poor practices. The part that my office and the other state agencies play in nursing home quality is that we help the facilities see where they have developed problems, hopefully before those problems have become serious and residents start dying.

Eliminating these regulations will not save anyone any money in the long run. There is no public policy position that we should save money by tying people up rather than having adequate staff to care for them. There is no public policy issue that the states are anxious to address or money any of us want to save by leaving seniors sitting for hours in their own excrement. There is no policy issue that should lead us back to the days when twice as many nursing home residents suffer dehydration as do today. Dr. Hawes and the Research Triangle Institute have demonstrated that these regulations SAVE money. I have not done the formal research but I know from experience that when my staff finds a nursing home with a high number of serious deficiencies, we have also found a nursing home whose residents are being admitted to hospitals more often, are requiring more physician interventions, and are therefore costing much more money than similar residents receiving proper care. We should also not forget that those residents are suffering more and dying more than residents receiving care in accordance with the regulations.

In considering the repeal of these regulations, we might look at the process that led from the passage of OBRA 87 to where we are today. As I recall, we started with a two year study by the Institute of Medicine which provided Congress with the basic requirements incorporated in OBRA 87. The principles incorporated in the law represented the agreements of over sixty organizations representing providers, consumer advocates, seniors, and the states. Following passage, the federal regulations and process took almost 3 years to finalize. Following the development of the regulations, I and others assisted HCFA in developing a new outcome oriented survey process to assess compliance with the regulations. I recall the long hours required to develop the training programs for both surveyors and providers to acquaint them with the new process. I personally conducted the training under HCFA sponsorship on quality of care and quality of life for over one half of the nation's 6000 surveyors. We then spent a year or two improving the process and learning the new regulations by applying them to the real world situations. HCFA codifies this knowledge base in the Interpretative Guidelines as well as in various policy dispositions. Within each state, we worked with the providers to continuously improve their performance in terms of the quality of care and compliance with the regulations. Just last year, my office sponsored a provider education program on restraint reduction because, even though Delaware was among the best in the country in this area, I know that we can all improve and, if we do, the residents benefit. Then this year, we had another flurry of activity with the Enforcement regulations going into effect with similar lengthy preparations and negotiations, similar training of surveyors and providers, and even more extensive post implementation analysis.

Should the proposals to revoke the federal standards go through, what type of standards should we expect from the states? In preparing for my testimony, I heard from various people that there is a general expectation on "the hill" that the states will basically adopt these federal standards as state standards. In preparing to speak with you today, I contacted approximately twenty of my counterparts across the country for their thoughts on what their states would do. Most states would look at what they could afford to do within the framework of reimbursement to providers as well as what type of inspection programs they could afford to maintain and, based upon that level of inspection, what type of standards might be enforceable. Several states quite clearly felt that their states would adopt bare minimum standards and they doubted that those would include any provisions in the quality of life or resident rights areas beyond whatever is mandated. Only one state told me they planned to adopt the federal standards largely intact.

However, leaving aside the specific predictions of the future, it is clear that the various states would adopt various standards, many based on the current federal standards but with differences. These differences from state to state will undoubtedly grow with time, as will the ways in which the different regulatory and judicial bodies within each state interpreted their own regulations. We will within a few years have 50 unique and distinct sets of regulations governing nursing home care. We will have 50 unique and distinct survey protocols and systems, assuming that all states maintain some level of inspection.

Transfer of the regulatory process would generate additional administrative costs to the states such as: developing standards; developing survey tools, software, protocols and processes; developing training programs for surveyors and providers; developing interpretative guidelines; developing hearing processes; defending the regulations against legal challenges; fielding new forms; and hundreds of minor tasks. It is important to note that each of these cost elements will be borne separately by each of the fifty states. With the exception of some of the largest states, the state agencies do not have the infrastructure to undertake this effort without a massive disruption to our ongoing inspection programs. I know that we have many fine organizations in Delaware but we have neither the time nor the funding to task our version of the Institute of Medicine to help us develop new regulations. I do not have a staff of regulation writers standing by awaiting orders. I do not have a training department sitting idle ready to crank out programs.

These costs will come to the states concurrently with the greater state burdens anticipated under the Medigrant proposals. The state survey agencies will be placed in the unenviable position of needing a larger share of scarcer state health care funds as we transition into the process of state

regulation. In most states, I would expect that we would not receive the funds required to thoughtfully develop comprehensive standards and to develop and implement effective and efficient inspection programs. In most states, we will be told (as we have been by HCFA for the past several years) to "do more with less." We can certainly be efficient but we cannot develop 50 good sets of regulations, 50 effective survey processes, 50 training systems, 50 sets of interpretative guidelines, and implement 50 inspection programs on our efficiency and knowledge alone.

I expect that the revocation of the federal nursing home standards, in that it will place the entire survey and certification burden on the states, will lead to a reduction in funding for this activity that will cause a substantial weakening of the inspection programs of many states. I know from my experience in traveling around the country that there is a direct correlation between the state's maintaining an effective inspection program and the quality of the nursing homes in that state. I therefore believe that this action will ultimately lead to a deterioration in the quality of nursing homes.

We are facing another challenge to the quality of our nursing home inspection program in FY 1996. The Senate Appropriations Committee has proposed reducing the state survey and certification funding from $152 million to $134 million. HCFA intends to use $7 million of these funds to support contract activities. This reduction will eliminate our ability to investigate complaints, conduct follow-up surveys to ensure that facilities have corrected problems, implement the enforcement regulations, and conduct the initial certification activities needed to allow new providers to participate in the Medicare program. Most importantly, this reduction will necessitate that we either go to biannual surveys of nursing homes or else so drastically reduce our time on-site as to severely limit the quality of the surveys' findings.

The end of federal regulations will also hurt the nursing home industry. As you know, a substantial segment of that industry is now either regional or national. These chains rely upon standardized procedures and training programs to allow them to provide quality care with greater economic efficiency. I have no idea how this segment of the industry will cope with 50 different standards, 50 different sets of expectations, and 50 different processes. The Delaware Health Care Facilities Association's Executive Director, Robert Lawson, was quoted in the Delaware State News as supporting the consistency provided by the federal standards and Paul Willging, Executive Vice President of the American Health Care Association told the New York Times that his organization "never took the position that the 1987 law should be repealed." Stewart Bainum, Jr., chairman and chief executive officer of Manor Care expressed his strong support for retention of the Nursing Home Reform Act of 1987. Mr. Bainum stated that OBRA '87

offers "a valuable means of protecting and promoting the quality of life for one of the most vulnerable segments of our population." As Mr. Bainum eloquently put it preserving the Nursing Home Reform Act and its standards "is the right thing to do."

I have not had the opportunity to review most of the specific legislative language being considered here and in the House of Representatives. However, I did want to comment briefly on some of the specifics of the legislative proposals I have seen. The Chairman's Mark in the Senate Finance committee on the Medicaid Certification Program contains some provisions that would greatly hamper our enforcement efforts under the regulations. The Chairman's Mark severely narrows the range of remedies available to the states and also includes a provision that facilities not complying with the regulation would be exempt from remedies if they were "making good faith efforts to achieve substantial compliance." As I have said, it is my experience that most nursing homes violate the regulations unintentionally and we certainly look at intentions in assessing appropriate remedies. This language however would take all the teeth from the states' enforcement efforts and would turn the process from an objective assessment of compliance into a subjective analysis of intention. It has been my experience that regulations are best which are clear and enforcement is most effective when all parties understand the rules. The regulations that are least effective are those that require government personnel to try to assess the good faith or intentions of others.

I am grateful to have been provided the chance to speak with you today and want to close by urging you not to let the citizens of any state return to the days where our spouses, our mothers, our friends, or any fellow citizens could be warehoused in nursing homes waiting to die. I never again want to visit a nursing home and see people who can still enjoy their lives demeaned and degraded by being tied to chairs and left in diapers and I especially do not want to return to the days where I could see that and be powerless to change it.

The CHAIRMAN. Thank you very much, Ms. Reap.
Dr. Hawes.

STATEMENT OF CATHERINE HAWES, SENIOR POLICY ANALYST AND CO-DIRECTOR, PROGRAM AND LONG-TERM CARE, RESEARCH TRIANGLE INSTITUTE, RESEARCH TRIANGLE PARK, NC

Ms. HAWES. Senator Cohen, Senator Pryor, thank you very much for holding this hearing.

I will try to just hit the high points of what is everyone else's long testimony. I spent 20 years trying to improve the quality of care in nursing homes. I started here sitting back there as a staff member on the Senate Aging Committee first under Senate Church and then under Senator Heinz. So I am pleased to be back but not happy about the occasion.

I also directed a legislative commission in Ohio in the late 1970's that looked at the conditions, and we found—you know, I was this naive little Ph.D. I thought we based public policy on evidence. So we went out to 10 percent of the homes in Ohio to see what the conditions were like. We thought that was the basis of law in this country, or should be, and what we found is that 20 to 25 percent of them were so horrible that they ought to be immediately closed. We found roaches crawling on residents, we found people laying in urine soaked sheets, we found all of the things that you've heard described today.

The first resident I talked to in a nursing home was carrying toast in his pocket, and when I asked him why, he looked around to see if any one would hear him, and he said, "Well, on days when we have breakfast I like to save something in case we don't have lunch or dinner." Those are conditions that we should not go back to, and without OBRA it will be impossible to ensure that it happens.

I hear the Governors say that—well, let me just tell you one other thing. I was also on the Institute of Medicine Committee. The thing that sort of kept me going is the belief that we could come up with laws that would work and a regulatory system that would have the inspection and the enforcement that would apply those laws in a uniform and fair way.

The IOM made its recommendations based on 10 years of State reports of the kind of quality I've described and the failures in the inspection and enforcement system and a request for between standards. All of those States—Arkansas, Missouri, Ohio, Texas, California—found exactly the same things, and none of them, including Ohio, enacted the regulations that we find in OBRA. We introduced the same regulations found in OBRA in 1979 in Ohio, and it took 10 years to get them passed.

We can't go back to State regulation. I mean, for one thing the elderly can't vote with their feet. If they don't like the care in Mississippi, they don't move to Minnesota. People deserve a standard, basic protection no matter where they live, and that's what OBRA does. What our research shows is that OBRA has been effective in human terms and in physical terms.

We conducted an evaluation that went on for 4½ years. It was in 10 States. We sent nurses into 269 nursing homes four times

over a period of 3 years to look at what was happening under OBRA. Before OBRA, 38 percent of the residents we found were restrained. Two and a half years later it was down to 28½ percent. It's now down to 20 percent. That's a quarter of a million people that aren't tied up any more because of OBRA.

Pressure ulcers, a 2-percent drop in pressure ulcers in a 2½ year period. That doesn't sound like very much but it's 30,000 people that don't get holes in their bodies that go down to the bone. We saw prevention of decline among residents. This is the amount of decline that was prevented in the activities of daily living for a population that's more impaired now than it was before. This is the amount of decline that we prevented in cognitive function because we reduced psychotropic drugs, we reduced physical restraints. Across the board more problems are being identified, more problems are being addressed in care plans, bad practices like physical restraints, and psychotropic are declining, good care practices like the—you know, you asked one of the former witnesses did they find anything besides restraints when you had a problematic resident. Behavior management programs are up 27 percent since OBRA passed. That's how you deal with not tying people up, not giving them chemical restraints. You put a behavior management program into place.

Thirty percent of the residents with hearing problems, 30 percent more have got a hearing aid today. It would be a travesty to do away with this law. When I hear Governors say that it is too burdensome or too costly, I wonder if they have ever looked at the research. Too costly for whom, their grandmothers? It's not even too costly for taxpayers. We estimated a $2 billion reduction in 1992, dollars for reduced hospitalizations alone, just hospitalizations.

I think it is cynical the basic tradeoff that underlies all of this—because I think what is being said is that the Federal Government will give less Medicaid money to the States, and the Governors implicitly say we're going to have to give less money to nursing homes so we're going to not look too closely at what you do. That places the burden for balancing the budget or cutting taxes squarely on the shoulders of 85-year-old widows who have worked all their lives, who have raised their families, who have seen their husband through a final illness, and impoverished themselves in paying for health care, and their reward is they should be tied up.

Let me just say one other thing that's not in my statement. The other horrible part of all this is at the same time that the bills would eliminate Federal standards they cut the ombudsman program to shreds. Now for all those people that don't have any family members that go in—and you saw how hard it was for families—there aren't even going to be ombudsmen to help them out, and then we cut legal aid for the elderly who are in nursing homes. Where is the fairness and the justice in this? Surely, that's not how you balance a budget in a fair and equitable society.

[The prepared statement of Mr. Hawes follows:]

/RTI RESEARCH TRIANGLE INSTITUTE

Social and Health Policy Research Center
Program on Aging and Long-Term Care

Statement Of
Catherine Hawes, Ph.D.
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Good Morning, Senator Cohen, and members of the Committee. Thank you for the opportunity to speak about the nursing home reforms which Congress enacted in the 1987 Omnibus Budget Reconciliation Act (OBRA) of 1987. My name is Catherine Hawes, and I am a Senior Policy Analyst and Co-Director of the Program on Aging and Long-Term Care at Research Triangle Institute. RTI is a non-profit research institute whose parent institutions are the University of North Carolina at Chapel Hill, Duke University and North Carolina State University.

I come to this hearing today in several roles and with a lot of history in the struggle to improve nursing home quality. For me, the first and most important role is that of a daughter whose mother who has been receiving informal long-term care from me and my husband for the past 7 years, while living with us. Thus, as a daughter and also as a woman who has a high probability of living long enough to need long-term care, I come with personal interest in what the Congress does about assuring quality in nursing homes and ensuring some measure of public support for those elderly and disabled who become impoverished in paying out-of-pocket for the care they need. Second, I appear as a former staffer of the Senate Special Committee on Aging, when the Committee was chaired by Senator Church and then Senator Heinz. The series of reports the Committee issued when I worked here were titled *Nursing Home Care in the United States: Failure in Public Policy*, which says much about where we stood 20 years ago. Third, I come as the former executive director of a State legislative commission that was charged with reforming Ohio's system for regulating and paying for long-term care in the late 1970s. We visited a random selection of 90 homes across the State in 1977-78, finding conditions that shocked and appalled us. In fact we found conditions so bad in between 20 and 25 percent of the homes that we felt the homes should be immediately closed. This included finding roaches crawling on residents, holes in floors that were so large you could put your arm through to the floor below, residents lying for days in urine-soaked sheets, 8 residents being washed and dried with the same wash cloth and towel because the owner was too

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stingy to buy sufficient linens but not too stingy to drive a company-owned Lincoln Continental or have 8 no-show family members on the payroll. We saw residents who died, scalded to death in bathtubs, residents who died from septicemia caused by bedsores as large as 8 inches in diameter and so deep you could see the bone, residents tied in chairs whimpering, "please, please, please," a resident who saved a piece of toast in his shirt pocket on days when they had breakfast in case there was no lunch or dinner. Week after week, month after month, we would stumble across these horrors, unsuspecting and never emotionally prepared for what we found.

Fortunately, we also saw good homes, some excellent, and they taught us what nursing home care could be and should be. Week after week, we saw great homes, adequate homes, and horrible homes, and we learned. We learned what good homes did to achieve better quality of care and life, and we learned how and why the regulatory system failed to protect us all from the horrible homes. So I come to you with first hand knowledge of just how far we have come over the last two decades.

I also appear as a member of the National Academy of Sciences Institute of Medicine Committee on Nursing Home Regulation. This is the IOM Committee that in the mid-1980s was charged with conducting a two-year study of nursing home regulation and with making recommendations to Congress and the Administration on how to improve the regulatory process and the quality of care received by residents. Finally, I appear as a researcher who has led projects funded by the Health Care Financing Administration (HCFA) and the National Institute of Mental Health (NIMH) that have assessed the effects of the OBRA-87 nursing home reforms and examined the relationship between cost and quality in long-term care.

I would like to make three basic points in my testimony. First, the federal nursing home regulations enacted in OBRA-87 have led to significant and widespread improvements in the quality of care received by the elderly and disabled in nursing homes. Second, these regulations are cost effective. Third, abdicating responsibility to the States for regulation of nursing homes would be both ineffective and inefficient.

Positive Effects on Quality. First, I would like to address the issue of whether the federal nursing home regulations contained in OBRA-87 are effective. The answer is an unequivocal and resounding YES, and this answer is based on empirical evidence not anecdotal stories or personal opinion.

Recently, RTI led a team of researchers that evaluated the effects of the nursing home resident assessment system, which is an integral part of the OBRA law. In that process, we also saw the effects of many other aspects of the nursing home reforms enacted in OBRA. My testimony today reports the results of a scientifically rigorous four-year evaluation and the conclusions reached by me and my colleagues, Dr. Charles D. Phillips of RTI, Dr. John N. Morris of the Hebrew Rehabilitation Center for Aged in Boston,

Dr. Vincent Mor of Brown University's Center for Gerontology and Health Care Research, and Dr. Brant E. Fries of the University of Michigan, Institute of Gerontology. The statements I make here today, however, do not necessarily represent the views of our organizations nor of the Health Care Financing Administration.

We found that since the implementation of OBRA in the nation's nursing homes, quality of care has dramatically improved. Moreover, improvements in nursing home care have significantly reduced the use of hospitals by nursing home residents, with an estimated savings of more than 2 billion dollars per year to the Medicare program. Thus, the OBRA nursing home provisions represent a tremendous success in both human and financial terms.

The evaluation employed a quasi-experimental pre-/post-test design, a complex multi-stage sampling approach, and a variety of analytic techniques to examine the effects of the resident assessment system and other aspects of the nursing home reforms on the quality of care received by residents. The sites we selected were 269 randomly selected nursing homes in 10 States. The States were selected based on differences in their Medicaid reimbursement rates (above and below the national average) and their average RN staffing levels in nursing homes (above and below the national average). As part of the evaluation, we sent out nearly 50 RNs who worked for and were trained at RTI to examine the quality of care in these facilities and to assess the health and functional status of more than 4,200 residents. Comparisons of process quality and resident outcomes were made between period immediately prior to the implementation of the OBRA-87 provisions (1990 and early 1991) and a post-OBRA implementation period some 2 and 1/2 years later (in the Spring and Fall of 1993). The major findings include the following:

1. In the post-OBRA period, there was a significant increase in the comprehensiveness and accuracy of the information available in resident's medical records about their health and functional status, care needs, strengths and preferences. This is important since such information is necessary to ensure that residents receive the care they need.

    - There has been a 24% increase in the accuracy of information the resident's nursing home record.

2. There was a significant increase in the comprehensiveness of care planning. The care plans in the post-OBRA period address a greater percentage of residents' health problems, their risks for functional decline and accidents, and their potential for improved function.

    - There has been a 17% increase in the number of problems that are addressed in care plans.

3. There were significant improvements in a wide array of care processes that affect residents' quality of care and quality of life, including:

   - A significant increase in the involvement of families and residents in care plan meetings and decisions. This is important to both quality of care and quality of life, since care plans can more accurately reflect the goals and preferences of residents.
   - A 30% increase in the use of hearing aids for persons with hearing difficulty
   - A 64% increase in the presence of advanced directives
   - A 7% increase in the provision of protective skin care, which is designed to prevent the development of pressure ulcers
   - A 27% increase in use of behavior management programs for residents with such behaviors as wandering, physical aggression, or resisting nursing care. This is significant, since the practice in the past was often to use physical or chemical restraints to deal with behavioral problems.
   - A 12% increase in the use of antidepressants and psychological therapy for residents with signs and symptoms of depression.

4. There were also significant reductions in troublesome care practices, such as:

   - A 29% decrease in the use of indwelling urinary catheters
   - A 25% decrease in the use of physical restraints in the period between late 1990 and early 1993. Federal survey data indicate that the rate dropped even further by 1994, with an overall reduction in the use of restraints of nearly 50 percent. This means, for example, that as many as a quarter of a million elderly were untied or never tied as a result of the OBRA nursing home reforms and the nearly universal acceptance of these provisions by the nursing home industry.
   - A 28% decrease in the percentage of residents who were not involved in activities any of the time

5. These changes in care practices led to improved resident outcomes. In particular, there was a significant reduction in decline among residents in such areas as physical functioning in the activities of daily living (ADLs include such activities as bathing, dressing, toileting and eating) and cognitive status. These findings are particularly noteworthy since helping residents attain and maintain maximum

practicable function has been a major goal of the OBRA nursing home reforms. In addition, we found such outcomes as:

- A 50% reduction in dehydration, and
- Decreases in nutritional problems and in the prevalence of bed sores (pressure ulcers). For example, an estimated 30,000 fewer people had bedsores in 1993, compared to the prevalence in the period before the new federal nursing home standards went into effect.

6. There was no increase in mortality in the post/OBRA period. However, there was a significant reduction in the number of hospitalizations and thus in the total days of hospital care among the nursing home residents over a six month period after the implementation of the OBRA nursing home reforms and the improvements in quality of care discussed above.

   - During the pre-OBRA period, we found that an estimated 28.4% of the nursing home residents were hospitalized during a six-month period. In the post-OBRA evaluation period, only 19.5 % of the residents were hospitalized. This represents a 25% reduction in hospitalizations.
   - If one uses Medicare data on payments for hospital care (an average of about $730 per day in 1992), this 25 percent reduction in the number of nursing home residents who are hospitalized yields an estimated savings to the Medicare program in hospital costs alone of more than $2 billion annually in 1992 dollars.

Does Good Quality Cost More? I think part of the reason that some Governors and perhaps some Medicaid directors say they favor abolishing the federal nursing home regulations in OBRA-87 is their belief that providing good care and improving quality always entails higher costs. In our evaluation of the OBRA nursing home reforms and in many other studies, my colleagues and I, as well as other researchers, have documented the fact that good care can lead to lower costs over time. Yet Governors and Medicaid Directors often take the word of the nursing home industry that any change for the better will necessarily cost more. For example, early on, nursing home providers in California argued that implementing the OBRA-87 provisions mandating reductions in the use of physical restraints would cost in the neighborhood of an additional $1.4 billion annually because it would mean adding staff to cope with the residents who had previously been tied up. Yet when two colleagues (Dr. Charles D. Phillips and Dr. Brant E. Fries) and I examined this issue, using nursing home staff time studies in six States, including Maine, Mississippi, South Dakota, and Kansas, we found that residents who were physically restrained actually took more not less staff time. Thus, reduction in the use of restraints should not increase nursing home costs. This article, whose lead author is Dr. Charles Phillips, was published in the *American*

Journal of Public Health in 1993 and has been consistently confirmed by clinicians in nursing homes around the country. Yet I've never heard it mentioned in Congressional debate over either OBRA's effectiveness or its cost. Yet the fact is that eliminating the federal standards will entail higher costs – in the burden of increased disability and substandard care the elderly would bear, in hospital costs, and in some cases, in nursing home costs, which are borne by the elderly, their families, and the American taxpayers.

Why Isn't Leaving Responsibility With The States Sufficient? My experience on the Ohio Nursing Home Commission and on the IOM Committee convinced me that effective federal standards are essential. The IOM reviewed more than a decade's worth of studies conducted by States about nursing home quality and regulation, one of which was our report from Ohio. The findings of these State reports were nearly universal about both the quality problems and the causes: standards that concentrated on structural requirements and the "capacity" of the home to provide good care rather than on resident outcomes; inspections that focused on paper compliance with the standards; and a deplorable lack of effective enforcement mechanisms. Yet nearly without exception, none of the States, including Ohio, were able to enact the laws needed to reform these deficiencies. Moreover, the States felt that the pre-OBRA-87 federal regulations were also ineffective. That was the status of nursing home regulation when the IOM conducted its study. Its recommendations grew out of the obvious knowledge of the States about what was wrong as well as the unavoidable conclusion that only federal action could remedy those problems. It was in this context that the IOM Committee made its recommendations and that the Congress, with broad bi-partisan support, enacted the OBRA nursing home provisions. Thus, as a practical matter, if we want effective and uniform minimum quality standards and better nursing home quality, federal regulations are essential.

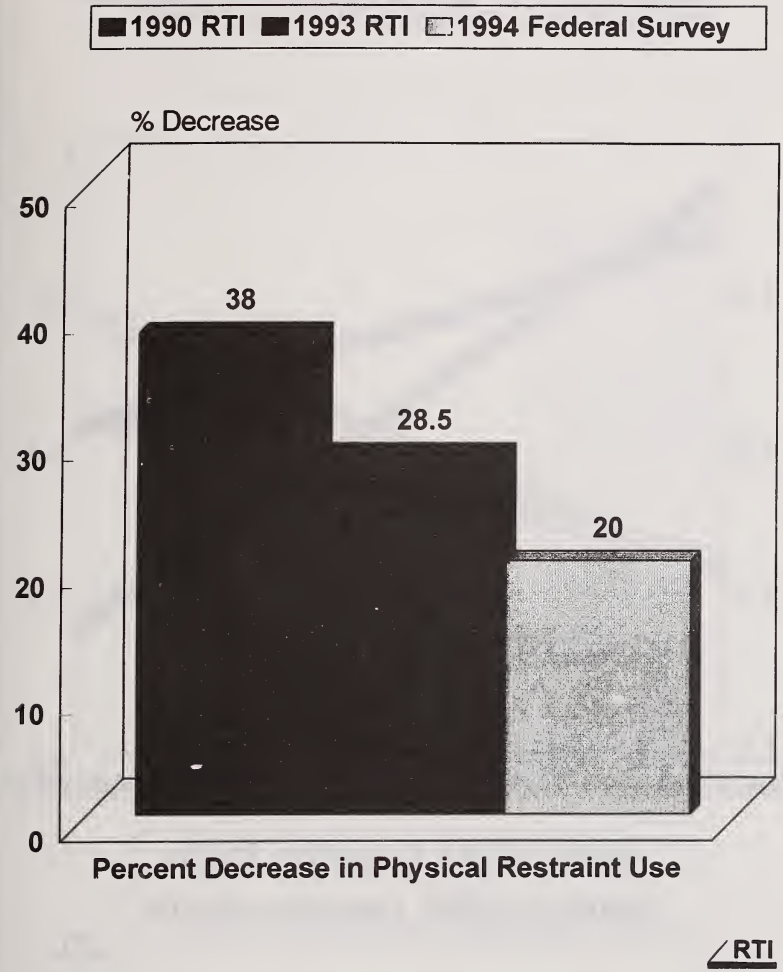
It is also important to note that retaining the federal regulations makes sense from a variety of other perspectives as well. First, it is extremely inefficient for each State to engage in the kinds of studies and political process that will be necessary to establish adequate standards, inspection processes and enforcement remedies if the federal standards are abolished. Only a handful of States have incorporated the federal OBRA-87 standards into State statute, precisely because they have been able to rely on the federal regulations. As a result, if the federal regulations are abolished, nursing home residents in most States would be left without the essential protections offered by current federal regulations. Second, substantial federal money flows to nursing homes through the Medicaid program whether it operates as it does currently or under a block grant. As a federal taxpayer, I feel I have a right to expect that such expenditures are subject to oversight that guarantees they are spent on acceptable quality of care and services. Third, I believe that the elderly and disabled residing in our nation's nursing homes have a right to the basic protections contained in OBRA, whether they live in Mississippi or Minnesota, New York or California. Finally, I would note that abandoning regulations which have been found effective in both human and fiscal terms is exceptionally poor public policy. It would signal the industry of providers, the elderly, and their families that the Congress neither cares

about quality nor intends to enact and preserve laws that protect the public interest.

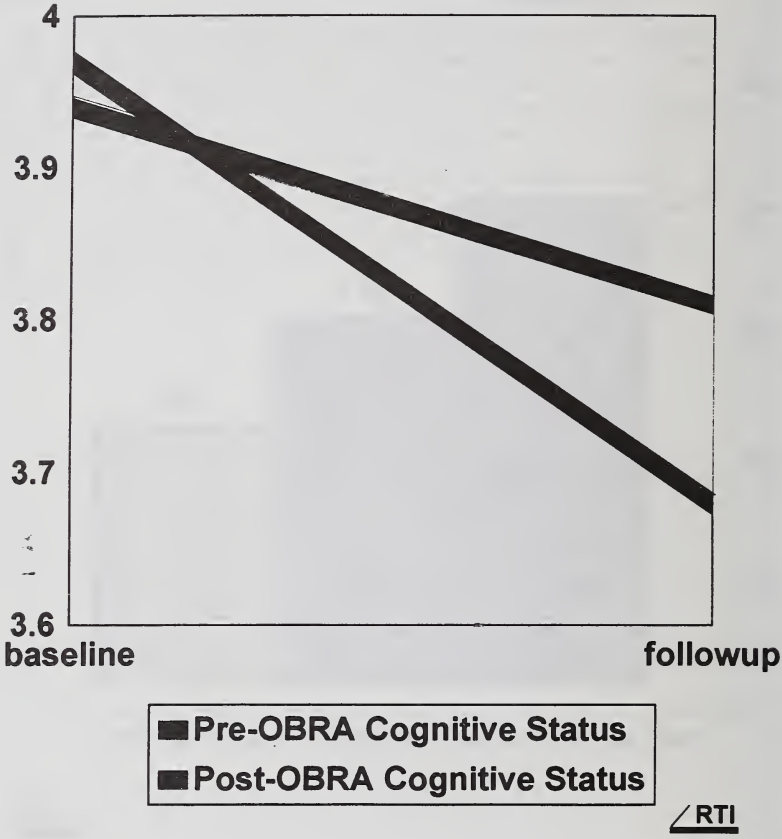
The reality is that the lives of our parents and grandparents are at stake here. These federal regulations are not part of some arcane statute that seldom if ever affects the average American. Instead, most Americans will at some time have a loved one enter a nursing home or will themselves be in a nursing home. Thus, what happens in the Senate and in the Conference Committee will profoundly affect the lives and well-being of most families. Moreover, I believe what happens on this legislation is a test of our national conscience.

Abandoning federal nursing home standards means nothing less than abandoning the elderly and their families across the nation. Any member of Congress who votes for such a proposition may justify that decision in righteous-sounding words about fiscal realities and State responsibilities, but the truth is that such a vote signals their willingness to place the burden of cutting taxes and balancing the budget squarely on the frail shoulders of 85-year old widows, women who have worked all their lives, raised their families, seen their husbands through a final illness and death, become disabled and impoverished in paying for health care, and find themselves dependent on the kindness of strangers. I cannot believe that is a message we wish to impart to our grandparents, parents, or children nor a reality we wish to impose on those who are among the most vulnerable members of our society.

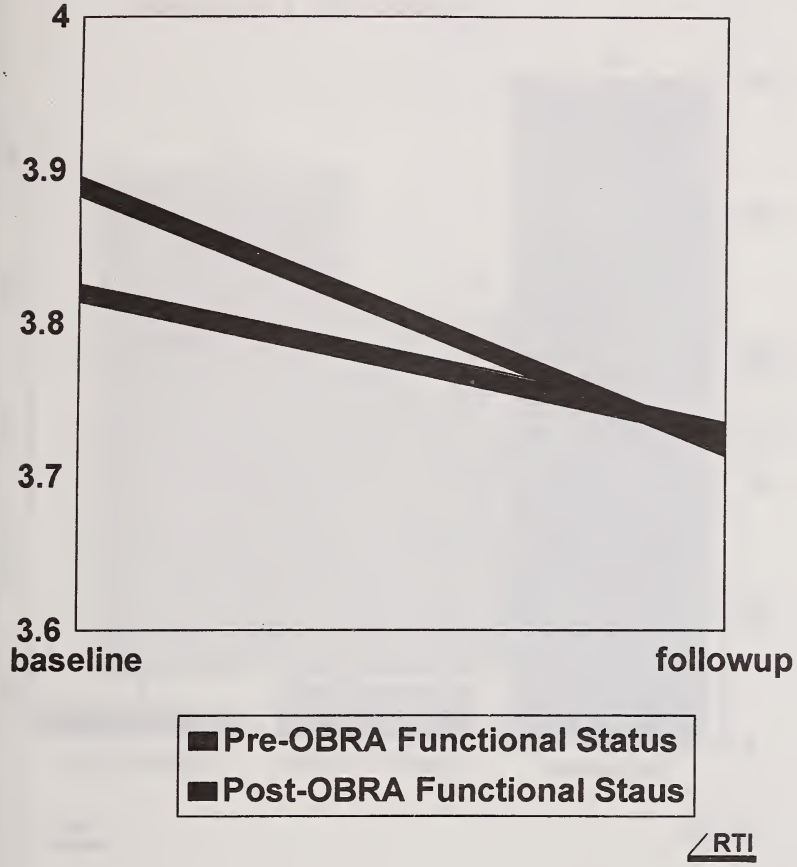
Physical Restraints



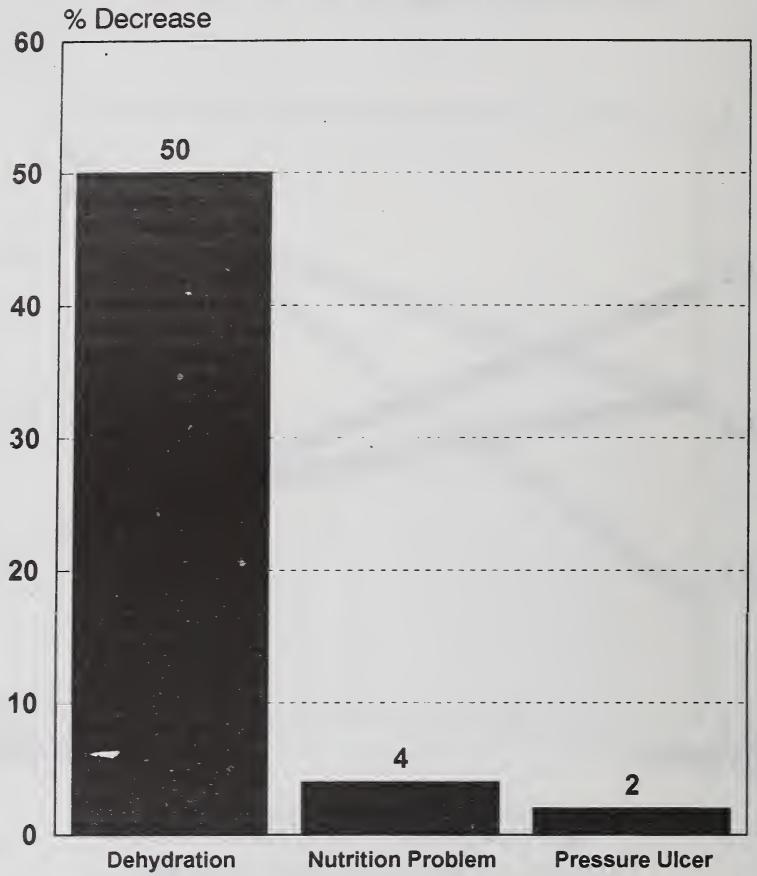
Improved Resident Outcomes: Maintaining Cognitive Status



Improved Resident Outcomes: Maintaining ADL Function

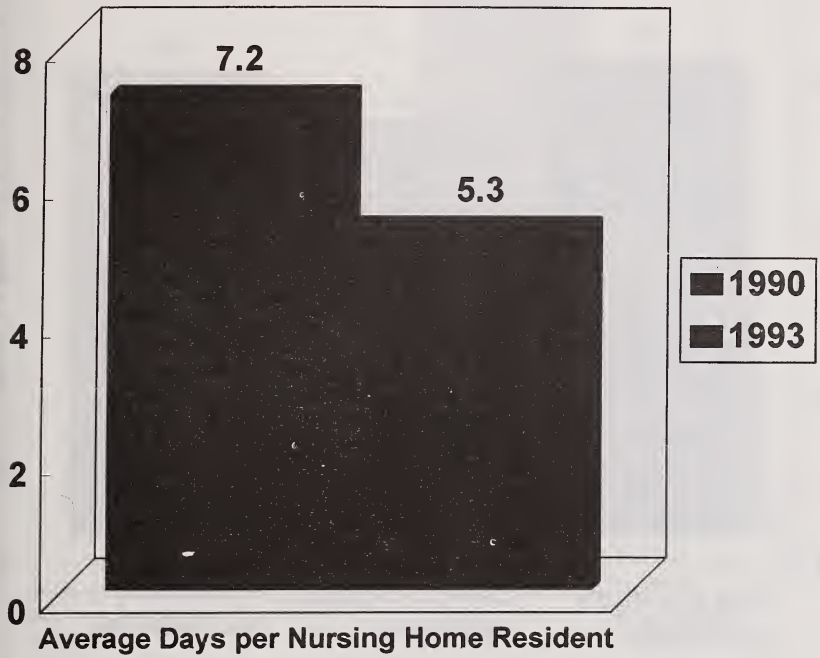


Resident Outcomes



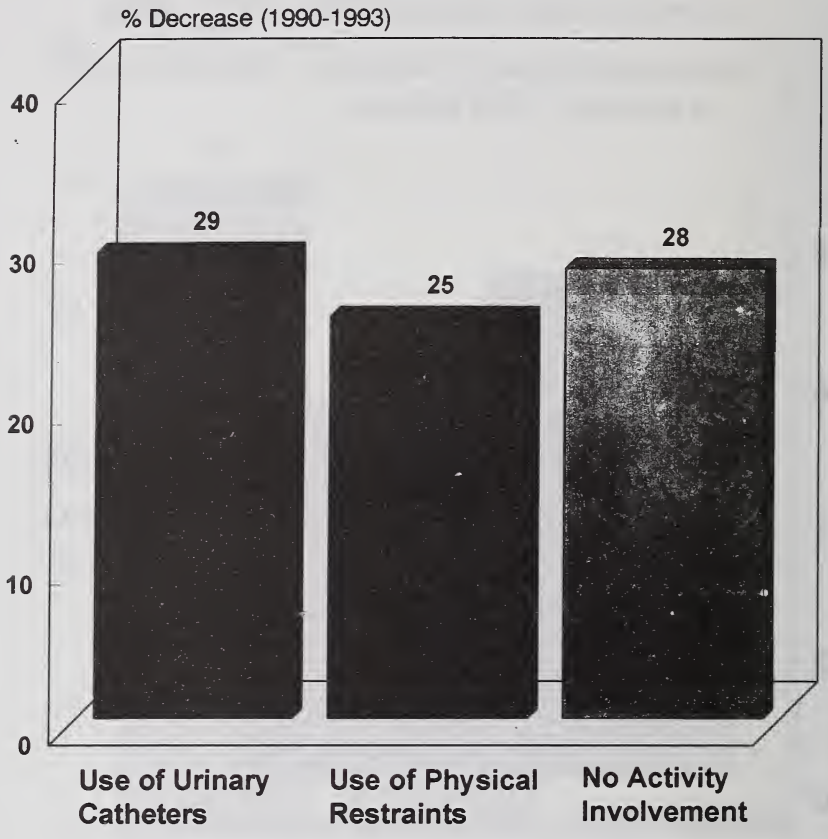
Decreases in Hospitalization

* Estimated daily hospital costs - $730 (1992)
* Estimated Impact on Medicare - $2 billion/year in savings (1992 dollars)

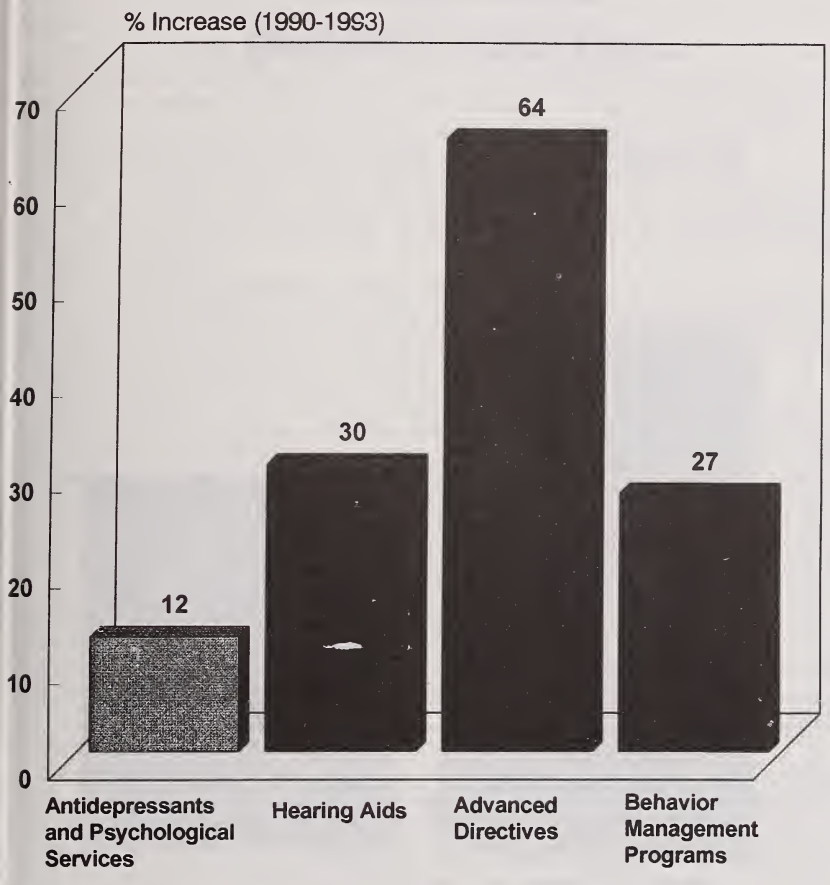


RTI

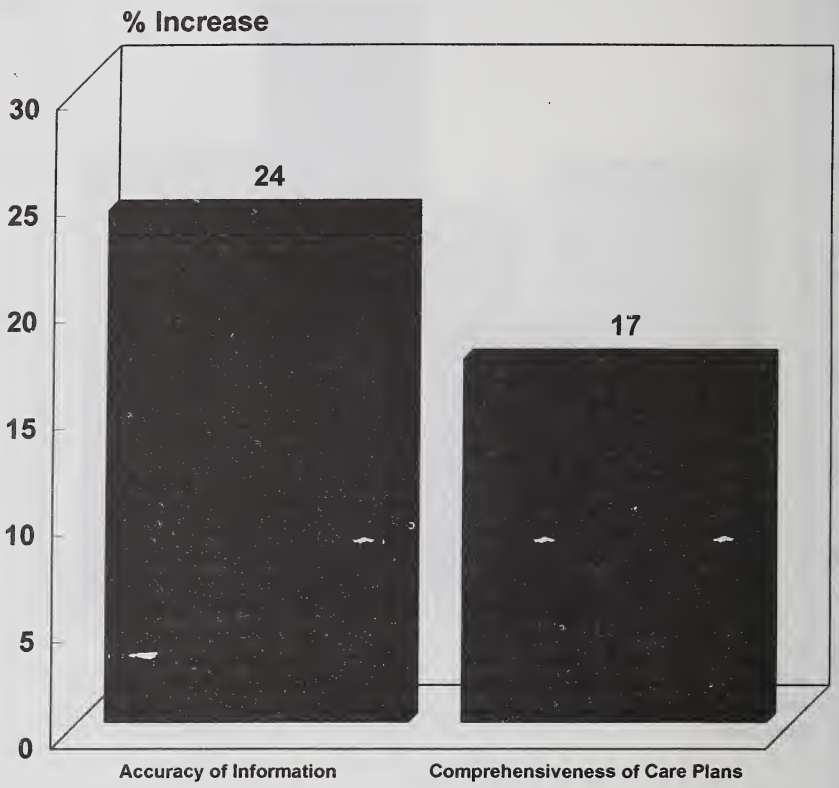
Decreases in Problematic Care



Improvements in Quality of Care



Improvement in Quality of Assessment and Care Planning



The CHAIRMAN. Thank you very much, Dr. Hawes.

I was going to say as you began with the possible exception of a slight tinge of an accent, if I close my eyes, I would hear Senator Barbara Mikulski talking. [Laughter.]

You have the same kind of energy and dynamism that she brings to the Senate. It was very evident in your voice.

You practically answer—the panel—all of the questions that I had prepared dealing with paper work burdens and whether or not really the paper work burdens are being funneled into OSHA requirements or fire safety codes and other types of requirements that nursing homes have to meet.

What I have found—one of my favorite quotes is from Oscar Wilde who said "The soul is born old, but it grows young; that is the comedy of life. The body is born young and it grows old; that is life's tragedy."

Over the years unfortunately most people have had the perception, as far as older people are concerned, that both body and mind or soul are old and have resorted in the past to let's just restrain them, or let's just medicate them, let's just keep them quiet.

What Senator Pryor and I have done over the years is tried to examine other ways of looking at people saying, well, the soul and the mind really is pretty young. If you treat it as such, we have looked, for example, instead of medication we've looked at music as a therapeutic process to follow. We have looked at art as part of the process to give people inspiration and a sense of joy in their lives whatever their ages. We've looked at all sorts of alternatives. If you treat people and give them a sense of purpose and a sense of dignity, it changes their psychological outlook. It changes their physical well-being as well, as opposed to just saying keep them quiet, keep them locked up, don't let them bang, put the restraints on, keep them injected. We've tried to insist that they be treated with the dignity to which they are entitled to in the final stages of their lives.

So we've, I think as a result of the Aging Committee's efforts over the years, been able to bring about dignified treatment, instead of looking at people in one generic way like they're all sort of interchangeable. It's like some sort of grain, that they're all alike and they're not—they're all different, we are all different.

So we have made serious and substantive progress over the years in how we treat our older citizens, and as a result of these standards, regulations, oversight and enforcement, very real changes and progress—I've been looking at these charts—have been made. So I, along with Senator Pryor, am committed to seeing to it that these changes are not abandoned. We are still in the process of negotiating right now, after 2 hours this morning, and it may be necessary for us to simply offer an amendment to restore OBRA, which we will do if necessary, and I believe it will pass. I believe it will pass with considerable support not only from Democrats but Republicans as well.

So we will know more about it at the end of the day, but your testimony for me has been very helpful because we intend to use these arguments during the course of debate. We intend to use the charts, and the graphs, and the showing of the progress and the

bed sores as well to say why it's important that we continue as we have.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

I don't have any real questions. I think this panel—they are all professionals, and you have testified in a most professional way. I would like to make, if I could, an observation, a prediction.

Senator Cohen, I predict in about 2 years you're going to see about 50 Governors coming to Washington, DC and they're going to say, "Please take this back. Please take all these responsibilities that you have passed upon us and upon our old tired poor backs, and you take them back, Federal Government." We're going to see a lot of that, and, you know, I'm not saying that's all good or all bad. I just think that it's going to happen. I don't think that the Governors have yet realized the tremendous, absolutely tremendous mandates basically, unfunded mandates, that are going to be placed on them as a result of what we're doing and major changes in how we look at government and its relationship with the private citizen.

So I would just predict—and a lot of those Governors are my friends. I used to be a Governor, but they're going to really see one of these days what we have done to them and they're going to be coming up here I think asking for a new partnership, and I think that day is going to come. I really hope that Senator Cohen is correct. I hope he can convince his colleagues to support the reinstatement of these very vital standards. I really hope he can—I think he can. If any one can, he can and Senator Chafee can, and if it takes a vote on the Senate floor, it will just take a vote on the Senate floor. I would predict that every Democratic Senator would vote for the restoration. I have not talked to each Senator, but I know that Senator Cohen can convince I think a large number of his colleagues to do so likewise. So I certainly hope that by the end of this week we will see these standards restored.

This hearing I think once again, Mr. Chairman, is so timely and thank you for calling it. I'm going to have to leave I'm afraid before the next panel comes.

The CHAIRMAN. Let me thank all the panel members for your testimony. It will be most helpful to us during the debate and we appreciate it very much.

Thank you.

Our final panel is comprised of representatives from the nursing home community. They are going to discuss how current regulations impact their facilities and how proposed changes in Medicaid reimbursement are undoubtedly going to affect the quality of care for residents.

The Committee welcomes Keith Weikel, who is representing the American Health Care Association and is a senior executive vice president of HCR Corporation in Toledo, OH; Sheldon Goldberg, president of the American Association of Homes and Services for the Aging; and, Dr. William Russell, director of Medical Services at St. Mary's Nursing Home in Baltimore, MD.

Thank you for waiting for your appearance here this morning. It's going to be very helpful to us as well, and we look forward to your testimony.

Dr. Weikel.

STATEMENT OF M. KEITH WEIKEL, SENIOR EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICE, HCR CORPORATION, REPRESENTING THE AMERICAN HEALTH CARE ASSOCIATION, TOLEDO, OH

Mr. WEIKEL. Thank you, Mr. Chairman, Senator Pryor. My name is Keith Weikel. I'm the senior executive vice president and Chief Operating Officer of Health Care and Retirement Corporation of America. HCR operates 150 long-term care centers, subacute and rehabilitation centers in 16 States throughout the Nation.

I am testifying today on behalf of the American Health Care Association, which is a federation of 51 affiliated associations that represent more than 11,000 non-profit and for-profit assisted living, nursing centers and subacute care providers nationwide.

As a former commissioner of the Medical Services Administration at the Department of Health, Education and Welfare and then Health and Human Services where I oversaw the operations of the Medicaid program, I have a keen appreciation for the policy questions facing you today. In addition to my 10 years at HEW and HHS, I served for 3 years as one of the commissioners of the Prospective Payment Assessment Commission, which gives me a great deal of empathy for the financing issues confronting Congress today in the area of health care.

I am pleased to have this opportunity to testify before the Committee on the issue of establishing, monitoring, and enforcing quality performance standards for long-term care facilities and how they will either be realized or abandoned through the implementation of a block grant funding mechanism for the Medicaid program.

From the outset of my testimony I want to make it clear that AHCA believes that the promulgation of clearly identifiable, strong standards including some direction in how these are to be achieved is a desirable and fundamental principle essential in the development of any health care delivery system, including long-term care. I hasten to add, however, we are equally adamant in our belief that as corollary to the development of any such set of standards providers must be given reasonable and adequate resources to meet any prescribed level of performance or expectation. It would be irresponsible of me to allow any of you to believe that you could simply achieve existing long-term care quality standards, while at the same time repealing the Boren Amendment, the Federal law which ensures that the necessary resources are made available to meet the goals and standards of the Nursing Home Reform Act adopted in 1987 that the American elderly expect and deserve.

Apparently lost in this debate is yet another option that we believe is available for consideration, and that is the utilization of the accreditation services of the Joint Commission on Accreditation of Health Care Organizations. Since 1963 HCFA accepted JCAHO accreditation for hospitals. In 1993 they accepted JCAHO accreditation for home health care services and in 1994 for clinic laboratories, and currently are developing those standards for ambulatory surgery centers.

JCAHO already has in place a comprehensive set of accreditation criteria for long-term care facilities, which have been used on a vol-

untary basis by numerous long-term care providers. A JCAHO survey will cost $7,500 in 1995 dollars versus HCFA's average nursing facility survey costs of $16,000 in 1993 dollars.

If Congress is truly to find ways to reduce health care expenditures, we would encourage you to consider this alternative survey system. I would urge this Congress not to address any individual component of the long-term delivery system in a vacuum, but rather in its entirety because ultimately the public policy that you seek represents the integration of a multitude of individual factors. To consider one without the others would result in a disjointed, fragmented and insufficient policy serving nothing more than a political agenda, and will ultimately not provide the funding necessary to meet the real needs of the elderly and the nursing centers throughout America.

Because of the complexity of this issue, we want to answer the question—does the AHCA support Federal oversight of nursing facility services? We are unable to responsibly answer this single question out of context from the multitude of equally important factors, many of which have been discussed here today. AHCA supports strong standards for long-term care. Who sets and oversees their implementation is a question Congress will have to deal with and is currently dealing with. It is possible that States could do as good a job in this area as the Federal Government. However, with the limited resources proposed, it is highly doubtful that they will be able to do so. The retention of existing Federal standards will impose upon the individual States significant costs that the proposed block grant funding levels simply fail to meet.

The only way in which Congress can ensure that the delivery of today's level of care continues is to provide for adequate resources for all providers of service. If Congress simply perpetuates existing standards of care while simultaneously reducing the Federal level of resources available to meet current and projected levels of demand, you will be offering a hollow promise to the frail, elderly and disabled to reside in America's long-term care facilities. This is not a supposition; it is a fact.

With regards to specific recommendations, the provider community would propose to make the nursing home laws more effective and cost-efficient as well as focusing more on those real quality concerns that we're all concerned with here today. Allow me to offer some of the following for your consideration:

First, repeal the pre-admission screening and annual resident review requirement, which is designated to identify mentally ill and mentally retarded individuals so that they are not inappropriately placed in nursing facilities. While the goal is laudable, it is a costly and duplicative service whose objectives could as easily be achieved through the resident assessment process that we have already heard about. Both the administration and the National Governor's Association support this proposal.

Second, modify the standards under which a nursing facility can train nursing assistants. Training is essential, important and critical. Currently law requires that the nursing facilities lose their ability to operate facility-based nurse aide training programs for no less than 2 years if the facility has received citations or fines, even though they're deficiencies are totally unrelated to nursing services

or resident care. The loss of such a program hinders not only the ability to train, but also the ability to recruit adequate nursing personnel which is so critical to serving the needs of the elderly in the provision of quality care.

We believe the termination of a facility-based training program should be linked only to the quality of the training program itself, and let me say there are thousands of very dedicated nursing assistants out there today providing loving care to residents in our nursing centers. There are some that don't live up to that standard but they are the exception. We do need training, but some provisions of this Act currently really work against us being able to train properly, and in some counties in this Nation, because of the way the survey process is being administered now, there are no nursing centers that are allowed to train nursing assistants. That is working against the provision of quality assurance, and we think that must be addressed.

Third, there are other statutory provisions which should be reevaluated. We think some of those are the standards under which a facility is required to manage individual resident patient trust funds, and the unachievable qualifications that are proposed for physicians who can perform the mandatory psychopharmacological drug reviews that we heard before and the amount of training required for individuals to assist residents with certain specific tasks, such as feeding. We can have a volunteer come in and provide training, we can't have any one come in unless they are certified nursing assistants to provide feeding to the residents. That doesn't seem to add up so we need to address some of those issues.

While these issues represent operational difficulties for nursing facilities, of more immediate concern to us are the reasonably implemented survey certification and enforcement regulations, which went into effect July 1. This new survey process, as you know, took more than 7 years in the making and has wreaked havoc on the provider community because of some of the inconsistencies across the Nation from State to State from HCFA region to HCFA region. Initial findings from HCFA generated by more than 2,700 surveys found around the country reveal wide discrepancy between region and Statewide findings in key areas of the survey process, including the average number of deficiencies per inspection, surveyor scope and severity ratings, the percentage of facilities found to be out of compliance with Federal standards, and the types of sanctions being proposed by each State and HCFA region. We believe the primary failure of this new enforcement system is that it does not ensure survey or surveyor consistency, a hallmark of the statutory requirement in OBRA 87 reforms. We believe that this shortcoming can ultimately be resolved, but the data generated by the initial survey finding points to an unacceptable level of subjectivity in this new survey rule, and as such has labeled otherwise qualified providers as not being able to meet even minimal Federal standards. Obviously, the label "out of compliance with Federal standards" shakes the faith of the public who when no other options are available must seek out nursing facility care for a relative or a loved one.

AHCA has shared with the staff of this Committee its specific recommendations, which we believe will improve the quality of care

as well as the costs and the efficiencies of the nursing home reform laws.

In conclusion, Mr. Chairman, allow me to summarize my remarks. Providers of long-term care services strongly support consistent and uniformed standards for long-term care. However, we cannot endorse the development of new standards nor the perpetuation of existing standards without adequate resources necessary to meet these standards and expectations. Current funding levels are essential to meet current Federal and State requirements. By retaining these standards and repealing the Boren Amendment, the failure of nursing facilities to meet these goals and expectations is a foregone conclusion.

We appreciate the time you have put in to holding these hearings, and want to again emphasize we're strongly in support of standards.

[The prepared statement of Mr. Weikel follows:]

PREPARED STATEMENT OF M. KEITH WEIKEL, PH.D

Mr. Chairman, members of the Committee, my name is M. Keith Weikel. I am the senior executive Vice president and chief operating officer of Health Care and Retirement Corporation of America (HCR). I am testifying on behalf of the American Health Care Association (AHCA). AHCA is a federation of 51 affiliated associations that represent more than 11,000 non-profit and for-profit assisted living, nursing facility, and subacute care providers nationwide. My corporation, HCR, operates 150 long-term care, subacute care, and rehabilitative centers in 16 states. As the former commissioner of the Medical Services Administration at the former Department of Health, Education, and Welfare where I was responsible for administering the Medicaid program, I have a keen appreciation for the policy questions facing Congress today. In addition to my tenure at HEW, I served for 3 years as a commissioner on the Prospective Payment Assessment Commission which gives me a great deal of empathy for the financing issues confronting Congress today.

I am pleased to have this opportunity to testify before this Committee on the issue of establishing, monitoring, and enforcing quality performance standards for long-term care facilities and how they will be either realized or abandoned through the implementation of a block grant funding mechanism for Medicaid.

From the outset of my testimony, I want to make it clear that AHCA believes that the promulgation of clearly identifiable standards, including some direction on how to achieve these standards, is a desirable and fundamental principle essential in the development of any health care delivery system, including long-term care. I hasten to add that we are equally adamant in our belief that as a corollary to the development of any such set of standards, providers must be given reasonable and adequate resources to meet any prescribed level of performance or expectation.

The proposal before this Committee today, the retention of extensive Federal regulations for nursing homes, places providers of long-term care services in a classic "tug-of-war" between proponents of maintaining high quality standards and advocates for the repeal of the Boren Amendment, that Federal law which guarantees providers adequate financial resources to deliver services and goods to residents of long-term care facilities. It would be irresponsible of me to allow any of you to believe that you can achieve existing long-term care quality standards while at the same time, take away the necessary resources to meet the goals and standards of the Nursing Home Reform Act adopted by Congress in 1987. Ironically, as part of these reforms, Congress was compelled to amend the Boren Amendment to require States to provide corresponding additional financial resources to meet these quality standards. Why this Congress now believes that it can decouple these two mutually dependent features of our long-term care delivery system remains a mystery to us.

ESTABLISHING QUALITY STANDARDS FOR LONG-TERM CARE

Currently, the Congress is debating whether or not the Federal Government should retain responsibility for the oversight of ensuring quality of care in nursing facilities or alternatively, transfer this authority to the individual States as part of a block grant program. We, like you, have seen this question polarize various constituencies as well as Members of Congress, leaving both providers as well as bene-

ficiaries, perplexed as to the long-term care delivery system Congress intends to provide for qualified beneficiaries of public programs.

Most puzzling and disappointing to us is that Congress in general, and individual members of this Committee in particular, have isolated a single component of a very complex and vast array of issues to debate: "Who should have responsibility for overseeing the maintenance of quality in long-term care institutions, the Federal or State governments?"

Apparently lost in this debate is yet another option available for consideration: the utilization of the accreditation services of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Since 1963, HCFA has accepted JCAHO accreditation for hospitals for the purposes of certification. In 1993 HCFA began recognizing JCAHO accreditation of Home Care for Medicare certification and in 1994 its accreditation of laboratories as meeting Federal Clinical Laboratory Improvement Act requirements. Currently, JCAHO is in the process of developing accreditation criteria for Ambulatory Surgery Centers. JCAHO already has in place, a comprehensive set of accreditation criteria for long-term care facilities which have been used on a voluntary basis, by numerous long-term care providers as an additional, "seal of approval" for their facilities. In fact, JCAHO's standards for long-term care facilities either meet or exceed existing HCFA requirements. They address issues of quality in all their scope and depth and they require that facilities have mechanisms to continually monitor quality. JCAHO relates outcome indicators to its survey standards which are to be used in continuing quality improvement and uses separate protocols for surveying nursing facilities, Dementia Special Care Units, and subacute care programs. Furthermore, as a budget consideration, the average JCAHO survey cost is $7,500 (1995 dollars) versus HCFA's 1992 average nursing facility survey cost of $14,349; if Congress is truly trying to find ways to reduce health care expenditures, we would encourage you to consider this alternative survey system.

Regardless of what private or governmental entity is ultimately deemed responsible for certifying long-term care facilities, without including in this policy debate the issue of ensuring adequate resources to meet whatever level of expectation Congress—or the States—decide upon, providers of services are doomed to failure in meeting current statutory expectations. I would urge this Committee, indeed, this Congress, not to address any individual component of the long-term care delivery system in a vacuum, but rather in its entirety because ultimately, the public policy that you seek represents the integration of a multitude of individual factors. To consider one, without the others, will result in a disjointed, fragmented, and insufficient policy serving nothing more than a political agenda.

Subsequently, we are constrained when this Committee poses the question, "Does the AHCA support Federal oversight of nursing facility services?" I am unable to responsibly answer this one question out of context from the multitude of equally important factors. Not surprisingly, paramount on the minds of my particular constituency is: "How will the States, under a block grant program, be able to finance the care and services mandated by either the State or Federal Governments?"

For obvious reasons, many individuals and organizations are also asking AHCA the same question, "Where does AHCA stand on the issue of standards for long-term care?" We appreciate this opportunity to address these questions in order to make our positions on these important matters known.

Does AHCA support standards for long-term care services?

Absolutely; AHCA supports the establishment of clearly identifiable standards for long-term care providers;

Does AHCA support retention of federal oversight for maintaining long-term care quality?

Conceivably, individual States could develop and effectively implement strong and effective quality standards in conjunction with effective enforcement mechanisms. However, Congress must support and demand that all States provide for a uniform set of quality expectations for beneficiaries and providers of long-term care services.

Does AHCA support such a uniform set of quality standards?

Absolutely; a basic premise of our nation's public policies in this regard is that all residents of long-term care facilities should enjoy the same standards of care. We urge you to retain this fundamental tenet of our national commitment to our nation's elderly, infirm, and disabled.

Does AHCA support the Finance Committee's block grant funding for Medicaid, long-term care services?

No. AHCA believes that the funding proposed by the Senate Finance Committee for long-term care services falls far short of the resources necessary to meet today's standards of resident care and services.

Does AHCA believe that the current Federal statutes (Nursing Home Reform Act of 1987) governing long-term care facility operations should be perpetuated in their entirety?

No. No law is perfect, including this law. In fact, since its enactment, the nursing home reform provisions of OBRA 87 have been amended no fewer than 30 times. Additional modifications should be made in order to make the delivery of services more cost efficient and effective as well as more focused upon the needs of our residents.

Does AHCA believe that the framework of the Nursing Home Reform Act could be retained and perpetuated as a model for developing quality standards?

Yes. The statutory provisions of both the Senate and the House of Representative's MediGrant proposals contain requirements for state long-term care programs for nursing homes that are very similar to the original provisions of the Nursing Home Reform Act. We fully expect that the States would ultimately impose similar standards.

Does AHCA believe that quality of care would suffer if states were to implement individual long-term care programs as proposed and financed by the MediGrant plan.

Yes. Under the block grant funding proposed by the Finance Committee, States stand to loose approximately 18 percent of their Federal payments for long-term care services. The provider community fully expects to bear the majority, if not all of the burden in realizing the implementation of this reduction in funding. *I can assure this committee that if such a reduction in resources becomes a reality, it will be economically impossible for providers to deliver the same level of services and care that are extended to nursing facility residents today.*

How can Congress ensure that an appropriate level of quality care will be afforded to residents of long-term care facilities?

By continuing current statutory provisions that mean that not only will quality expectations be met, but also that payors of services—the State and Federal Governments—will provide sufficient resources to providers to meet these expectations.

Mr. Chairman, members of this Committee, all of you know that if you retain existing standards of care, while simultaneously reducing the Federal level of resources available to meet current and projected levels of demand, you will be offering a hollow promise to the frail elderly and disabled who reside in long-term care facilities. This is not a supposition; it is a fact.

At this point, I would like to comment on both the merits as well as what we believe to be the failures of the current laws and regulations governing the nation's long-term care delivery system. As I mentioned, the nursing home reform provisions of OBRA 87 represent a sound framework for the development of a legislative infrastructure to oversee the operations of long-term care facilities. However, like many such laws, its shortcomings have been generated through its accompanying regulations; but even more onerous can be the subjective application of these regulations. This law and its subsequent implementation epitomizes the cliché, "The devil is in the details."

PROPOSED MODIFICATIONS TO THE NURSING HOME REFORM PROVISIONS OF OBRA 87

Following are some of the modifications to the original nursing home reform law supported by ACHA:

REPEAL THE PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW REQUIREMENT

In order to identify and prevent mentally ill or mentally retarded individuals from being inappropriately placed in nursing facilities, a preadmission screening and annual resident review (PASARR) screen was imposed upon providers. Once identified, such individuals (unless they required nursing facility services) were to be placed in appropriate settings and provided with necessary services. Although a laudable objective, the PASARR screening process is redundant and its objectives could be easily achieved through the mandatory resident assessment process. The costs associated with both the initial and subsequent screening process are borne by the States. In addition, any "specialized services" deemed necessary by the team of

health care professionals conducting the screen must also be borne by the State. By relying upon resident assessment protocols, States could save a significant amount of money which could be better utilized for resident's services.

MODIFY STANDARDS FOR FACILITY-BASED TRAINING OF NURSING ASSISTANTS

Federal law requires all nursing assistants employed in nursing facilities to undergo a standardized training and competency evaluation program. This is a necessary and appropriate feature of the nursing home law. The education and testing of nursing assistants may be offered by and in a nursing home. This too is beneficial in that it serves as an important nursing assistant recruitment and retention tool for facilities.

However, current law takes away this incentive by providing for the disapproval of facility-based training programs if the facility has received citations or fines (or both) even though these penalties may be totally unrelated to the quality of the nursing services or nurse aide training program itself.

Loosing the ability to recruit and train nursing staff is devastating to a facility. In tight labor markets, individuals who are trained in other facilities usually end up becoming employees there. Furthermore, current law institutes this prohibition for no less than a 2-year period; an unreasonable amount of time to penalize the facility and to prohibit facility-based nurse aide training; regardless of the findings of subsequent surveys.

The net result is that a facility which may have some problems totally unrelated to resident care is given another problem—in the area most important to ensuring that adequate nursing personnel are available to care for residents. AHCA believes that only facilities who experience significant deficiencies relating to their nurse aide training program should lose the right to train their nursing staff.

AMEND THRESHOLD REQUIRING MANAGEMENT OF RESIDENT FUNDS

Current law requires that any resident's personal funds in excess of $50 be held in an interest bearing account managed by the facility. Facilities managing resident funds are required to account for, allocate interest, distribute and receive funds from residents. This places an inordinate administrative burden on the facility in terms of personnel time and makes the facility tantamount to a bank. Although banking institutions may be used for this purpose, it is extremely difficult to find one willing to take responsibility for a large number of such small accounts. And if a facility is able to find a bank willing to serve in this capacity, monthly bank fees all but ensure that the principle would coon be diminished to zero. The threshold for management of these funds should be modified to a more reasonable level such as $250.00.

REPEAL PSYCHOPHARMACOLOGIC DRUG REVIEW

Current nursing home law requires that nursing facility residents receiving psychopharmacologic drugs must have the use of these drugs monitored no less than annually by a external consultant for their appropriateness as part of a drug regimen. This is not an unreasonable requirement, however, HCFA's proposed rules governing the definition of such an, "external consultant" in 1992 gave the following proposal for qualifications:

> "* * * a physician who has training or experience in geriatrics and psychopharmacology and who must not serve a facility with which he or she has had a contractual, financial, employment or familial relationship with the facility, its owner, its attending physicians, medical director, or administrator within any of the 36 consecutive months prior to the date of the review."

The limitations outlined in this proposed rule would disenfranchise virtually every potential candidate professionally qualified to perform these reviews. Areas subjected to physician shortages would especially be hard pressed to locate qualified professionals to perform these services.

This provision is also duplicative. Current regulations regarding the use of unnecessary drugs prevent the misuse of this category of pharmaceuticals. Existing regulations governing drug regime review and their misuse are currently required to be performed on a monthly basis and adequately meet the goals of this provision.

PERMIT APPROPRIATELY TRAINED INDIVIDUALS TO ASSIST RESIDENTS

Current statute and regulation limit those individuals eligible for providing services to nursing home residents to be either "licensed health professionals" or under

the purview of nursing assistants. Nursing assistant services are not specified in statute, but are delineated in regulation.

In certain areas experiencing labor shortages nursing facilities have sought the ability to utilize compensated individuals (not certified as nursing assistants) trained in the provision of specific services such as assisting residents during meals. However, Federal regulations do not allow for the use of such individuals unless they are certified as nursing assistants. Such standard discourage these individuals from potentially serving in this capacity. However, if the same individual were to perform identical services in an uncompensated capacity, which Federal law and regulation permit (i.e., as a volunteer), no infraction of law or regulation would exist.

Nursing facilities have sought the ability to utilize non-certified personnel, with adequate training, but because they were compensated, they are denied the opportunity to serve in nursing facilities. AHCA believes that if services are of a limited scope and nature, task-specific training and testing criteria could be developed in order to expand the potential caregiver population thereby relieving labor shortages.

ENFORCEMENT REGULATIONS

Mr. Chairman, the preceding examples are representative of some of the issues AHCA believes need to be addressed legislatively in order to further refine OBRA nursing home standards. Since its enactment, this body of law has been amended no less than thirty times; clearly nobody has made the claim that it is a "perfect" law. The staff of AHCA has shared with both the Majority and Minority staffs of this Committee, more detailed proposals for further amendments. We recognize that some may view these proposals as, "going too far." However, if we experience the budget shortfalls that we have calculated, this Congress must be prepared to dramatically lower its levels of expectations from providers who will, as we predict, bear the brunt of the block grant initiative.

Most recently, and of a more immediate concern to providers of long-term care services are the recently implemented survey, certification, and enforcement regulations which were published on November 10, 1994, and implemented on July 1, 1995. This new system represents a dramatic change in the way nursing facilities are surveyed for compliance with Federal requirements and for the first time, created a system of intermediate sanctions for noncompliant facilities. For the first 90 days of this new survey system's application. HCFA conducted a "test" period under which an assessment of the rule's impact on providers could be conducted.

Initial findings from this 90-day test period have revealed alarming findings. During the test period, over 2,700 surveys from around the country reveal huge variations among States and HCFA regions in both the survey process and the resulting enforcement system. In the States of Utah and Nevada, for example, 100 percent of facilities surveyed have been found in substantial compliance with applicable requirements. By contrast, 99 percent of facilities in Michigan and 93 percent of facilities surveyed in Minnesota have been found to be out of compliance with applicable requirements and potentially subject to various remedies. In HCFA region No. 10, 87 percent of facilities surveyed have been found out of compliance with requirements. HCFA region No. 5 follow closely with a noncompliance rate of 79 percent. By contrast, 54 percent of facilities in region No. 9 and 64 percent of facilities in HCFA region No. 8 have been found to be out of compliance. These numbers—at first glance—appear to represent an indictment of the long-term care provider community. However. they must be viewed in the context of the findings of the survey system that preceded this new one which found approximately 85 percent of all long-term care facilities in the United States to be in compliance with *identical standards* only 8 months ago. Clearly, these wide discrepancies point to the failings of the survey system itself, not the performance of individual nursing facilities.

HCFA's own data report wide discrepancies between regional, statewide, and prior year disparities in several key areas of the survey process, including: the average number of deficiencies per inspection; surveyor scope and severity ratings; the percentage of facilities found to be out of compliance with Federal standards; and the types of sanctions being proposed by each State and HCFA region. This data points to an unacceptable level of subjectivity in this new survey rule and as such, has labeled otherwise qualified facilities as not being able to meet even minimal Federal standards. Aside from the impact on the provider community, this system has shaken the faith of a public who, when no other options are available, must seek nursing facility care for a relative or loved one. From our perspective, the survey system, in its current form, is a disservice to beneficiaries and providers alike. We do believe that ultimately, the shortcomings of this new survey system can be worked out. AHCA, as well as representatives of other long-term care providers are working

closely with HCFA to resolve this issue. Until such time that the necessary refinements in this system are made, we encourage HCFA to extend and continue its testing period. We have several proposed statutory and regulatory modifications applicable to the new survey rule. Again, we have shared copies of our proposals with the staffs of both sides for consideration.

CONCLUSIONS

Obviously, this Committee would like to retain Federal oversight of the delivery of long-term care facilities providing services under the Medicaid program. We are doubtful that the same level of enthusiasm exists for ensuring that providers of these services will have the necessary and adequate resources made available to them in order to meet these objectives. It's impossible for me to convey to you the level of anxiety the provider community is experiencing over the proposed block grant funding program. In our view, this public policy proposal will inflict great harm on beneficiaries and providers alike. I must however commend you, Mr. Chairman, and the individual members of this Committee for at least giving some thoughtful consideration to this issue.

Thank you for this opportunity to present our views on this important matter. I'd be pleased to answer any questions you may have at this time.

The CHAIRMAN. Thank you very much, Mr. Weikel.

Mr. Goldberg.

STATEMENT OF SHELDON L. GOLDBERG, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, WASHINGTON, DC

Mr. GOLDBERG. Thank you very much, Senator Cohen.

My name is Sheldon Goldberg. I'm the president of the American Association of Homes and Services for the Aging. I represent over 5,000 not-for-profit providers of care across this country, providing care to almost a million people as we sit here today.

I want to commend you, first, as a champion—as a champion for individuals who has great appreciation, concern and compassion, and the same is true also for Senator Pryor, and, second, for your leadership for looking at this issue. We very much appreciate that.

I appreciate this opportunity to speak. I recognize the schedule is tight, and I will move quickly.

I submitted a lengthy statement for the record. You have that, so my remarks will be direct and frank and I will come to the issues as quickly as I can.

I have to say, though, with all due respect, that although OBRA 87 may have institutionalized some concepts of quality, OBRA 87 did not invent quality in nursing homes. The providers had a great deal to do with that as well, and they've been doing it for a long time.

Nursing homes that have been providing quality care predate OBRA 87. Many members of our organization predate Medicaid and Medicare, some predate the Constitution, and they have been committed to providing quality care for people in their frail years for many, many years—literally centuries.

Some have touted OBRA as being responsible for all the innovation and as something new, but I want to stress that much of the innovation in the long-term care field has come from the provider community. Interestingly enough, it was not OBRA but the provider community that pushed and moved the restraint reduction requirements in this country—nursing homes initiated that concept. It was the provider community that also developed ways to respond to and care for Alzheimer's disease patients and those with

similar conditions. That kind of innovation and creativity will continue, regardless of how we define quality in law and regulation and regardless of how it is enforced. We acknowledge, though, that quality in nursing homes is not always consistent, and there are some providers who are not adequate for that job. Because of that, we have supported OBRA as a necessary Federal presence in long-term care. People work in this field for a variety of reasons, and regulation has been something of an equalizer in situations where individuals' dedication and motivation have not been sufficient to guarantee high standards for the people they serve. We would be grateful for a Federal presence in long-term care if it not only established the floor for long-term care standards, but also backed up those standards by requiring that States recognize the cost of care. This is one of the things we are so concerned about as we move forward with this public policy. It is for that reason our Association has opposed block grants, and it is for that reason we are also very, very concerned that Medicare is in jeopardy at this time.

We agree that both programs, Medicare and Medicaid, may need to be trimmed in the interest of stabilizing our national economy. We have no question about that. But we're on record that these cuts have to be fair and they cannot be too deep. If they come too fast, they will jeopardize the health of frail elderly Americans.

At this time, we understand that rapid attitude adjustment is going to be forced upon us. Our concern is that, as a part of that adjustment, we do not want managed care for residents operating simply on a shoestring. Even in the most optimistic projections regarding the impact of the Medicare and Medicaid cuts, we see, at a minimum, reductions of 25 to 35 percent of the cost of care coming over the next 7 years.

Let me deal with reality—the reality is that the acuity level of nursing home residents is rising. Study after study has demonstrated that the residents we care for are much sicker than in the past. Higher acuity residents have higher costs. Labor costs continue to rise, and these costs are for the employment of important people in the lives of residents. Our employees have families', they have obligations. They deserve living wages. They also deserve benefits. Other nursing home costs—such as food, maintenance, medical supplies, and utilities—are ever increasing. Add to that the cost of the enforcement system, which at this moment seems to be going astray, and I have to tell this Committee, and you, Senator, that we don't know whether the OBRA 87 nursing home reform provisions should be preserved in the context of Medicare and Medicaid cuts. We would support continuing these standards if we knew that they were working, if we knew that they would promote quality, diminish marginal care and enhance those homes that provide quality care.

But since the new enforcement system was implemented on July 1, 1995, we have had little to say in support of OBRA and our support of it is diminishing. We supported the new enforcement system and its concept, and its concept was that it be would outcome-oriented, that it would be fair. There would be a process that would identify good facilities and give them recognition, and poor facilities would be forced to do better.

Instead, we have a system in which some States have cited between 90 and 95 percent of the facilities in those States for being out of compliance—that's unbelievable. We submit that the enforcement system is not only failing to promote distinguished facilities, but it is absolutely obscuring some of the care and you can't tell the difference.

OBRA has accomplished a lot—I stress that. OBRA has accomplished a lot, but unfortunately the new system, as it's being implemented at this time, makes it hard to decipher where and by whom the goals of OBRA are being accomplished. It is for that reason we believe very strongly that OBRA has to be looked at—at least its implementation at this time.

The monetary damages, the paper work, the additional burdens on nursing staffs, the effort to correct inappropriate citations—these obviously have our members reeling. I have never seen them as concerned and sensitive about Federal regulations as they are now, and that has to be adjusted and fixed appropriately.

One issue remains, though, and that is the nursing facility standards under the Medicare program, because public policy is creating dual systems. Since the same Federal standards and enforcement systems exist for both Medicare and Medicaid, we don't believe that OBRA 87 will have any more significance for Medicare than it will have for Medicaid, if this proposal goes forward. We need to focus on how we can fix these systems and how Federal oversight of the Medicare program will be administered with respect to nursing homes.

Maybe we should be looking at some form of accreditation, or deemed status. We have had that for years in the hospital environment, in the home care environment and otherwise, and perhaps much of the resistance that exists is that nursing facilities have been locked out of that process. Perhaps that process can involve them as equal partners in the process of moving forward, and perhaps through deemed status for accreditation, we can actually create a better enforcement system that responds to the needs of people.

The question on the table is what will happen if the Federal standards are removed? It will not make any difference for those who are committed to providing quality care and have done so for a long time, but I will also be very candid with you. For other homes, it will have a very important impact because they have not performed well. But for most, the professionalism in this field has changed dramatically since the beginning of the whole program in nursing homes and the creation of Medicaid and Medicare. Managed care has instilled competition, and there are other alternatives that make nursing homes a better place and operate in a better environment. Higher acuity has attracted higher professional staff to the facilities, and they have a great deal to do with the quality that's going on.

In public education, hearings like this get information to residents and families about residents' rights, and the need for consumers to become knowledgeable and to demand care that is responsible.

Homes that have consistently provided quality care some even before the Medicare and Medicaid programs existed, will continue

to do so because their motivation depends neither on money nor on regulations. It's about commitment. It's about the purpose for which they exist. I also know, as you know, that there is a percentage of facilities that will continue to provide marginal care. For those providers there always needs to be some form of oversight, but I am struck by one last issue. The policy seems to be very inconsistent. We need to be consistent in our expectations for nursing home care and our willingness to pay for care. We cannot create block grants, remove reasonable and adequate payment requirements, and enforce a set of standards without a corresponding commitment to pay for residents' basic needs, to reimburse for a fair quality of care within those homes. We are moving in two totally separate directions with where we're going on quality of care and where we're going on reimbursement.

I urge you to look at the care issues in OBRA, but also to look seriously therefore moving on this block grant to the States as well, and consider the consequences I thank you for your sensitivity and your attention.

[The prepared statement of Mr. Goldberg follows:]

PREPARED STATEMENT OF SHELDON L. GOLDBERG

Mr. Chairman and Members of the Committee, I am Sheldon L. Goldberg, president of the American Association of Homes and Services for the Aging (AAHSA). I appreciate the opportunity to appear before the Senate Special Committee on Aging today to share with you AAHSA's perspective on the effectiveness of the Federal Medicaid standards for long-term care facilities, and, in the context of converting the Medicaid program into a State-administered block grant, the current proposal to eliminate them.

The American Association of Homes and Services for the Aging is a national nonprofit organization representing more than 6,000 not-for-profit providers of care in nursing homes, senior housing facilities, continuing care retirement communities, assisted living, and community services to more than one million individuals daily. With a tradition of strong community involvement and longstanding community ties, AAHSA members remain committed to meeting the physical, social, psychological, emotional, and spiritual needs of their residents in a manner that enhances their selfworth and dignity, and encourages them to function at their maximum level of independence.

OBRA 87

The nursing home quality reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid. AAHSA supported the passage and implementation of OBRA. We were one of the initial members of the Campaign for Quality Care, the coalition of organizations coordinated by the National Citizens' Coalition for Nursing Home Reform, that worked to reach consensus on twelve key areas of nursing home reform. As you are aware, several of these consensus positions were reflected in the final OBRA 87 provisions. Throughout the phase-in of nursing home reform, AAHSA has continued to serve on various committees and workgroups convened by the Health Care Financing Administration to work toward a reasonable and equitable implementation of the regulations and interpretive guidance resulting from the OBRA requirements. As a national association we have remained an advocate for the presence of these Federal standards because we believe that many of the policies and care practices of our members have been enhanced as a result of these provisions.

One of the most significant transformations resulting from the passage of OBRA 87 was its intent to shift regulatory oversight from facilities' *capacity* to provide care, i.e., "paper compliance" with requirements, to one of *resident outcomes,* that is, the actual care provided. Several of the provisions were designed to facilitate this change and have improved quality of care to assure better outcomes. These provisions include (1) the mandate that every facility conduct "initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity". This requirement has resulted in the development and success-

ful national implementation of the Resident Assessment Instrument and Minimum Data Set (RAI/MDS); (2) the requirements in both legislation and regulations that nursing facilities "provide and assure that each resident receives the necessary care and services to attain and maintain his/her highest practicable physical, mental, and psychosocial well being."

This mandate has placed facilities in the unique position of being the only health care provider to be mandated to guarantee specific resident or patient outcomes. This language not only assures that resident outcomes will be stressed as a measure of quality of care, but also places a clear responsibility on nursing facilities not just to maintain the status quo, but to act aggressively to improve the resident's health status; (3) the elimination of the SNF/ICF distinction, meaning that all nursing facilities are required to have twenty-four hour licensed nursing staff and a registered nurse for a least 8 hours a day, 7 days a week. OBRA 87 and the Federal regulatory system require that facilities have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable * * * well being of each resident"; and (4) the mandate that all nurse aides employed by nursing facilities meet minimum training and competency evaluation requirements.

RESIDENTS' RIGHTS

A renewed awareness of residents' rights is another critical focus of care that has emerged from the passage of OBRA 87. Throughout its 35 year history, AAHSA has championed residents' rights. The increased emphasis that has resulted from OBRA is a position that fits squarely into the Association's basic philosophy that aging is a natural process that should not limit or change a person's right to autonomy and to experience life to its fullest. AAHSA members have had a longstanding commitment to care for the total person. This commitment recognizes that residents' rights extend beyond the basic protection of civil liberties and legal rights to include the concepts of quality of care and quality of life. In 1975, prior to the enactment of Federal standards, AAHSA's membership adopted its own resident "Bill of Rights." Over the years, the Association also has made available to nursing facility administrators and the general public such publications as *Social Components of Care,* identifying those physical or program arrangements that allow and encourage residents to realize themselves fully as individuals with personal dignity and as members of the community; and *Resident Decision Making in Homes for the Aging,* a step-by-step guide to starting a resident council or improving an existing one. Additional AAHSA publications have included a series of consumer brochures to help elderly individuals better understand the variety of housing, services, and care options that are available to them, and *Enhancing Autonomy in Long-Term Care: A Training Manual for Nursing Homes.* In March 1993 AAHSA sponsored a *Symposium on Aging, Design and Regulations,* to address avenues and innovative ideas for improving the environment of nursing facilities.

AAHSA's most recent and current initiative is to develop and test a valid, standardized, reproducible nursing facility customer satisfaction system. Historically, most research on indicators of quality in nursing facilities has focused only on clinical indicators related to quality of care. For nursing facility residents who may be spending the rest of their lives there, quality means so much more than the clinical care they receive. Quality of life for these individuals also revolves around how well the nursing facility is meeting their needs for autonomy, dignity, choice, companionship, food and environment, and safety. Our assessment will measure how important these key elements are to residents and to their families, and how well nursing facilities are doing at meeting those values and needs. Our approach will ask what it is that the individual resident and his/her family desire, and then ask whether they are getting it. The end result will provide nursing facilities with more concrete guidance on what changes to make to improve consumer satisfaction. One of our key goals is to be as inclusive as possible in obtaining resident satisfaction data, since cognitively impaired residents, who make up the majority of nursing facility populations, are rarely queried directly about their satisfaction. To this end, we are working to develop an instrument that is individualized, based on each resident's cognitive status and independence level. We believe this to be one of the most exciting projects we have ever undertaken and look forward to its' testing and completion in 1996.

REDUCING USE OF RESTRAINTS IN LONG-TERM CARE FACILITIES

Finally, a most important and positive outcome of OBRA 87 has been the national initiative to reduce or eliminate the use of physical and chemical restraints in nursing facilities. Again, as not-for-profit providers of care, AAHSA and its members have taken a leadership position in promoting restraint-free care. Kendal

Crosslands, an AAHSA member, was the developer of the program, "Untie the Elderly" that has gained national prominence in the context of providing guidance and technical assistance on this critical quality issue. AAHSA also has provided assistance with restraint reduction through its publications *Minimizing Restraints in Nursing Homes: A Guide to Action;* and *Restraint Minimization Programs,* a description of nine different restraint reduction programs being utilized by AAHSA facilities. We have served as distributor for *Retrain, Don't Restrain,* funded by a grant from the Commonwealth Fund, New York, NY and acted as advisor on the development of *Everybody Wins! Quality Care Without Restraints,* a video library about creative ways to provide quality care without restraints, also supported by the Commonwealth Fund of New York.

CONCERNS

AAHSA generally supports the principles of OBRA 87. We have serious concerns, however, about several statutory provisions, regulatory requirements, and implementation issues that have proved to be unworkable and/or unnecessarily expensive.

DISQUALIFICATION FOR NURSE AIDE TRAINING

Under current law, Medicare and Medicaid prohibit nurse aide training *by* or *in* a nursing facility for a period of 2 years if the facility, within the previous 2 years, has: (1) operated under a waiver; (2) been subject to an extended or partial extended survey; (3) has been assessed a civil monetary penalty of $5000 or more; or (4) has been subject to certain remedies (denial of payment for new admissions, temporary management, termination of its provider agreement due to a finding of immediate jeopardy, and/or closure of the facility, transfer of residents, or both). These provisions are severely restricting the ability of nursing facilities to recruit and retain adequate nursing personnel to train nurse aides; they also are increasing the costs of training and are proving counterproductive to improving quality of care to residents.

There is little argument for continued approval of a nurse aide training program by a facility providing substandard quality of care. However, under the law, nursing facilities that have been excluded from training cannot even bring outside trainers into their facilities to conduct training onsite. Many homes, particularly rural facilities, are located in areas where access to alternative training programs is limited. Not being able to bring trainers into the facility presents a hardship for both the facility and the nurse aide who must travel to be trained. As a result, a number of facilities are finding it extremely difficult, if not impossible, to assure training for their aides. The problems already being experienced by these homes are compounded by their inability to obtain training for their staff. Thus, the effect of the sanction on the quality of care being provided is negative rather than positive.

An amendment to the law should be effected to allow recertification of a facility's nurse aide training program once compliance has been achieved. This will preserve the ability of the facility to assure the ongoing provision of required training and competency evaluation of its nurse aides. At minimum, the prohibition on providing nurse aide training *in* a facility as a result of noncompliance must be deleted. This will at least offer providers the option of assuring adequate staffing and care by properly trained aides via programs conducted on facility premises by outside, State-approved training programs.

REPAYMENT OF MEDICAID FUNDS

OBRA 87 requires that nursing facilities achieve compliance within 3 months of a determination of a deficiency, but Federal payment to a provider may be continued up to 6 months if three conditions are met: (1) the Secretary of the State finds it is more appropriate to apply an alternative remedy to termination; (2) the State has submitted a plan of correction that is approved by the Secretary; and (3) the facility (under Medicare) or the State (under Medicaid) agrees to refund the payments made by the Federal Government under this arrangement should the facility fail to achieve compliance within the specified extended timeframe.

AAHSA's major concern with these requirements is the impact of the Medicaid provision on already-strained State budgets. No State is willing to assume additional financial risk by agreeing to repay the Federal match should a facility not achieve timely compliance. The result of this provision is a defacto elimination of the use of intermediate sanctions as alternatives to termination. This contradicts the intent of the law to promote compliance through the use of appropriate remedies. It also is having a resoundingly negative effect on facility reputations and staff morale, as well as on the public perception of the quality of care in nursing facilities. To date, approximately one third of all nursing facilities surveyed after

July 1, 1995, have received termination notices as a result of this technicality in OBRA.

Elimination of the requirements for repayment of Federal funds is necessary to fulfill the intent of OBRA that intermediate sanctions be available as alternatives to termination. At minimum, we urge you to secure an amendment under Medicaid that would enable *nursing facilities* to agree to repay the Federal match if corrections are not made on a timely basis, as the comparable Medicare statute provides.

ABBREVIATED MDS

OBRA requires that the standardized Resident Assessment Instrument/Minimum Data Set (RAI/MDS) be completed within fourteen days of admission. However, there are a number of nursing home residents who, although exceeding a fourteen-day stay, reside in the facility for such a short time (less than thirty days) that the full RAI/MDS is not always appropriate. These are residents who may be admitted for a short-term intensive skilled rehabilitation, for a brief respite care stay to relieve family caregivers, or who may be hospice care patients in the very terminal stages of disease. Completing the full RAI/MDS in these instances is a burdensome endeavor, in terms of both cost and time, that does not yield benefits commensurate with the effort. To avoid these unnecessary and excessive expenditures a more limited assessment and care planning process is warranted for those residents who are to be discharged from the facility within thirty days of admission.

DUPLICATION OF PASARR AND MDS ASSESSMENT

OBRA currently requires that the Annual Resident Review mandated under the provisions for Preadmission Screening and Annual Resident Review (PASARR) for mental illness (MI) and mental retardation (MR) be performed by the State mental health (MH) and mental retardation (MR) authorities. This annual resident review is conducted for residents of nursing facilities who have been determined to be MI or MR. It duplicates much of the standardized resident assessment (RAI/MDS) that is annually and periodically required for all nursing facility residents. These assessment efforts must be coordinated to reduce or eliminate duplication of efforts and expense. At minimum, State authorities should be permitted to determine whether the information contained in the resident's current RAI/MDS is sufficient to make a decision regarding continued need for nursing facility and/or specialized services, particularly for long-standing, stable MI or MR residents. Further study of these two assessment processes should be conducted to determine what additional duplicative efforts can be eliminated.

EXTENDED SURVEY CYCLES

While the survey and enforcement process is designed to respond quickly to issues of noncompliance, there is little or no "reward" built in for excellent facilities, even though both the law and regulations call for such incentive programs.

Survey and certification authorities currently are required to survey all nursing facilities on a nine to fifteen month survey cycle, with an average of twelve months, regardless of the quality of care provided by the facility. A lengthened survey cycle for facilities that have demonstrated high quality of care over an extended period of time, would be an appropriate incentive for good homes and allow survey agencies to target limited resources on marginal or poorly functioning facilities.

IMPLEMENTATION OF FINAL RULE ON ENFORCEMENT

AAHSA is extremely concerned with the preliminary results of the implementation of the revised long-term care survey, certification, and enforcement process. The most recent Health Care Financing Administration (HCFA) data indicates that the vast majority of nursing facilities in this country, 73 percent, are not in compliance with Federal requirements, and that 18 percent are actually providing substandard care. Based on these statistics, a reasonable consumer would be perfectly justified in concluding that 8 years of concentrated efforts to improve the quality of care in nursing facilities has been a failure, and that care is actually becoming dramatically worse, not better.

The results of the surveys thus far give no clue about whether these numbers truly indicate the quality of care being provided in nursing facilities. We think they do not. There are a number of issues, in addition to the repayment of Federal funds discussed above that we believe are contributing to an overly punitive enforcement process and a misperception of the care being provided to nursing facility residents. First, sufficient time was not afforded to prepare for implementation. Late last spring, when it was clear that it would not be possible to train all surveyors or nurs-

ing facilities on the changes to the new survey and enforcement process by July 1, AAHSA asked HCFA for a brief delay in implementation. HCFA refused, and we are seeing the results. Delays in HCFA's distribution of the State Operations Manuals, which contain all the survey and enforcement procedures and interpretive guidance, has meant that many nursing facilities were simply not aware of changes that have since culminated in avoidable deficiencies.

We have heard repeatedly that surveyors concentrate more on fine details related to process than on resident outcomes. This may be a response to survey procedures emphasizing that any finding not clearly in compliance with every aspect of the requirements is a deficiency at some level. This focus on process-related details contradicts HCFA's stated intent that very minor or isolated instances of noncompliance would not be identified as deficiencies, and the Administration's goals to streamline the survey process and place much greater emphasis on outcomes. Nursing facilities thus must spend more time addressing the "paper issues" of documentation and compliance, leaving less time for actual resident care, contrary to everything OBRA 87 stands for.

AAHSA believes there is a flaw in the process and the definitions being used to measure severity and scope and to apply deficiency determination. OBRA's and HCFA's goals were to impose remedies in proportion to the severity of the deficiency (punishment should fit the crime) and to promote sustained compliance. The current definitions of severity and scope do not appear to be accomplishing this objective. The definitions are confusing, and this confusion has resulted in disproportionately severe penalties for providers who misunderstood some of the requirements.

Another historic problem OBRA set out to address was the significant, unexplained differences (inconsistencies) in rates of deficiencies and assessment of penalties between facilities, between surveyors, and between State agencies. Variations in survey results seem to have been exacerbated rather than relieved under the new survey and enforcement process.

AAHSA was very pleased to see that the final enforcement regulations mandated that States implement informal dispute resolution processes as a means of resolving disagreements on noncompliance issues prior to formal appeal. We were distressed, however, to learn of HCFA's subsequent interpretation that the process be limited to consideration of only the existence of a deficiency, and not the severity or scope of a finding. Such a restriction is not supported by either law or regulations, and unfairly limits a nursing facility's ability to obtain redress for inappropriate sanctions. A fair and equitable dispute resolution process is crucial to the validity and integrity of the survey and certification process. The fact that better than one half of dispute resolution processes are resulting in reversal of citations, even with HCFA's restrictions, attests to the fact that many deficiency determinations are not accurate.

Perhaps most importantly, the new survey and enforcement process is having a devastating effect on the morale of staff in nursing facilities. AAHSA understood that the enforcement process would differentiate between facilities providing poor care and those providing good care. Instead it appears that the process portrays the vast majority of facilities as bad, often for very minor or inconsequential reasons. A rapid and thorough reassessment of this system is required.

RECOMMENDATIONS

If Federal standards are to be retained, the following changes in OBRA must accompany any reforms to Medicaid:

- Permit recertification of a facility's nurse aide training program once compliance has been achieved. At minimum, delete the prohibition on providing nurse aide training *in* a facility as a result of noncompliance.
- Eliminate the requirement that States repay Federal funds as a condition of imposing intermediate remedies as alternatives to termination. At minimum, allow nursing facilities to agree to repay Federal Medicaid funds if timely correction is not achieved.
- Mandate Federal development of a short-stay RAI/MDS and care planning process for those residents who are to be discharged from the nursing facility within thirty days of admission.
- Eliminate duplication of efforts by State MH and MR authorities by allowing these entities to use current RAI/MDS information for residents with MI or MR for annual decision-making about continued need for nursing facility and/or specialized services.
- Allow a lengthened survey cycle under Medicare and Medicaid for up to 24 months for nursing facilities that have demonstrated compliance with all long-term care requirements for two consecutive surveys.

• Clarify that informal dispute resolution processes be opened to consideration of severity and scope for any deficiency.

IMPACT OF PROPOSED MEDICAID BLOCK GRANTS

While recognizing that the Committee's intent was for this hearing to focus on retention of the Federal standards rather than financing issues, it is an unfortunate reality that the two must be considered halves of a single equation and cannot be discussed in isolation.

The current OBRA requirements must be examined in the context of the budget reconciliation legislation that is now pending in Congress. This bill takes the unprecedented step of converting an entitlement program, Medicaid, into a block grant to be administered by the States. Total spending on the program will be subject to annual caps that would be set so as to cut the projected growth of Medicaid expenditures by 182 billion dollars over the next 7 years.

We recognize the fiscal realities facing this Congress; however, the amount of funding to be removed from Medicaid is excessive and will negatively affect both access to nursing home care and the quality of care that our facilities will be able to provide. Medicaid already reimburses nursing facilities at rates that are dramatically lower than the actual cost of caring for residents who are very frail and in need of a wide range of services. According to testimony given at this summer's congressional hearings on Medicaid, program costs have risen primarily due to the growth in the numbers of people who have become eligible for Medicaid. Under the pending legislation, States will have to make hard choices on whether to cut back on Medicaid eligibility or on the services to be covered by Medicaid in order to comply with the proposed spending caps. States will therefore be under severe pressure to cut reimbursement for nursing home care back to even more inadequate levels.

As a final blow to providers, the proposed legislation would repeal the Boren amendment, and in effect, would repeal the Congressional covenant with quality care in nursing facilities that was established with the passage of the OBRA 87. The Boren amendment was designed to give States more flexibility in designing reimbursement policies for nursing facilities. It requires the State's Medicaid plan to provide for nursing home payment rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulation, and quality and safety standards * * * ."

After the OBRA 87 nursing home quality reform provisions were passed, Congress amended the Boren Amendment to recognize explicitly the costs associated with those standards. The payment rates for nursing facilities must "* * * take into account the costs (including the costs of services required to attain to maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under the title) * * *"

The legislative history shows that Congress intended to give States broad rate-setting power, but those States were not to use arbitrary rate methodologies that could negatively affect resident care. The rates also needed to take into account projected economic conditions, such as inflation. Congressional intent indicated that States were not to set Medicaid rates based solely on budgetary appropriations. There is every reason to fear that, given the elimination of the Boren Amendment by the Medigrant Program, and the drastic cut in Federal spending for beneficiaries' health care, States will hasten to cut payment to providers. Nursing facilities can eliminate as much waste and inefficiency as possible, but there are not many dollars left there to be saved. Quite frankly, it is an insult to the many providers of quality care to suggest that repealing OBRA will return nursing facility conditions to the "dark ages," but it is equally unrealistic to expect facilities to absorb the increased costs of meeting the OBRA provisions with lower Medicaid reimbursements. To repeal the Boren Amendment guarantees neither continued quality nor increased efficiency. The likely outcome will be diminished access, compromised quality, and ultimately, no true cost savings because the consequences will be borne by the American public.

Lowering Medicaid reimbursement rates means that the provision of quality care creates a stress for facilities that can be felt from the top down on a staff level and by all residents, regardless of payment source. This environment makes it almost impossible to attract and retain the kind and level of staff needed to assure the continuation of high quality of care. Unlike hospitals, nursing facilities do not perform expensive tests or invest in high-tech equipment. On average, 70 percent of an AAHSA facility's budget goes for staff salaries, primarily for the nurse aides who provide hand-on care. A 1988 report by the Commission on Nursing of the Department of Health and Human Services found that on average, registered nurses in

nursing facilities earned thirty-five percent less than their hospital counterparts. Similar salary differentials existed for licensed practical nurses, nurse aides, and other nursing personnel in the same area. Such disparities in salary levels for long-term care nursing staff are due, in large part, to already inadequate Medicaid reimbursement rates. AAHSA members have always been at the forefront of efforts to improve the quality of nursing home care, but this progress depends on the recruitment and retention of qualified and well-trained personnel.

AAHSA recognizes that efforts to balance the Federal budget will affect health care as well as all other Federal programs. We support provisions of the pending budget legislation that are designed to crack down on waste, fraud and abuse in the Medicare and Medicaid program. We also support the concept of managed care, under which frail elderly people would be cared for in a variety of settings, not only in nursing facilities. In fact, many AAHSA members already provide home- and community-based care and other alternatives to nursing home care. However, neither managed care nor reductions in waste, fraud and abuse are expected to result in the amount of savings that would be required under the budget legislation.

Notwithstanding the many valid and important reasons for retaining a Federal presence in the Medicaid program, if current thinking prevails, the existing Medicaid program will soon be transformed into block grants giving the States authority to design and administer health care for the most vulnerable persons. Within this context, each State will be given the responsibility for developing and implementing a quality assurance program for nursing facilities.

The absence of a Federal presence to provide oversight and enforcement of quality standards affords an opportunity to examine other approaches for quality assurance and oversight, including deemed status. If designed and implemented by qualified organizations with the active and continuing involvement of consumers and providers, this method of insuring quality can be both efficient and cost effective.

CONCLUSION

Innovation and creative caring will continue, regardless of who defines quality and how it is enforced.

We have been grateful for a Federal presence in long-term care not only because it raised the floor of long-term care standards somewhat, but also because the Federal Government backed up those standards by requiring that the cost of care be recognized by the States. For that reason, our Association has opposed block granting the Medicaid program.

Reducing the Medicaid program to block grants assumes that Medicaid as a Federal program, with its safeguards for both consumers and providers, was a mistake. We respectfully disagree. Further, we have supported a strong Federal Medicare program, and that, too, appears to be in jeopardy. While we agree that both programs must be trimmed in the interest of stabilizing our nation's economic future, we are on record as saying that the cuts are too deep and too fast for the health of the system, as well as for the health of frail and vulnerable persons.

Senator you want to know whether the OBRA 87 nursing home standards should be preserved in the context of Medicaid and Medicare cuts. There is no simple answer to such a complex question. Those homes that provided quality care before Medicare and Medicaid existed will continue to do so, because their motivation depends neither on money nor regulations. For those providers, the Federal enforcement system, as it is currently being implemented, is unacceptable. The combination of this process and Medicaid block grants is intolerable and unnecessary.

Unfortunately, there is a percentage of facilities that continue to provide marginal care. For these providers, there always will be some need for oversight. It is the States' contention that they can provide this oversight, and it appears that Congress is on the verge of giving the States that responsibility.

I again thank you for the opportunity to present AAHSA's perspective on these issues.

The CHAIRMAN. Thank you very much, Mr. Goldberg.

Dr. Russell.

STATEMENT OF DR. WILLIAM RUSSELL, M.D., DIRECTOR OF MEDICAL SERVICES, ST. MARY'S NURSING HOME, BALTIMORE, MD

Dr. RUSSELL. Thank you, Senator Cohen, and I will be very brief. I will try not to repeat any of the important information that has

been presented because it's true and it's clear we're preaching to the converted.

I'm a physician—I do this. I think I'm the only person——

The CHAIRMAN. You're preaching to the preachers. [Laughter.]

Dr. RUSSELL. I do this. I'm going to get on that 12:30 train to Baltimore and go upstairs to the nursing home and take care of patients. I have no ax to grind. With all due respect to Sheldon whose work I respect and whose position I support, this industry is not well prepared to respond to the needs of the future. Ninety percent may be the right number for facilities out of compliance. I can walk into any nursing home in this country and find problems—I have no doubt at that. I see and stand by the door of every resident in my nursing home once a week to give them the opportunity to talk to me, to look at the conditions they live in and to meet with the staff that takes care of them. It takes that level of commitment to make it happen. This is really hard work. It's incredibly hard work, and we owe it to these people to make it happen.

Of all the things that happened as a result of OBRA 87, it was the affirmation of the moral personhood of the people that live in nursing homes that was the most important thing. You are worthy of good care. You are loved, we will be faithful to you, we will honor our obligations to you, we will treat you like a person. A person is not defined by wholeness of body or by cognitive function. A person is defined by their membership in our society and that alone, and it is from that sense of commitment to people that our greatest treats come.

I can tell you I have no cure for the diseases that cause people to come to live in nursing homes, but I can treat them with respect, I can help the staff to do that by modeling those behaviors, and it is through the affirmation of their personhood that they can be restored to function.

I think we need to have higher standards. I think the norm for admission to a nursing home should be improvement in function. People come to nursing homes at the bottom after hospitalization with no choice. They land there completely disoriented on too many medications after an acute illness. We should be able to make those people better and that should be the norm, and we've done that in our facility and I think every facility could do that.

I think we need to look at tube feeding. There is an enormous tragedy going on in this country about tube feeding. One of the prior speakers talked about it, but many facilities keep people on tube feeding simply to get a Medicare level and to keep it for 100 days to get reimbursement for the bed. People keep people on tube feeding to get higher Medicaid reimbursements and that's wrong. More than half the people who get admitted to nursing homes on tubes can be weaned to natural oral feeding. It's time intensive, but the benefits are extraordinary. People will talk again, people will start to feed themselves again.

If we can do anything, let's design and build better nursing homes through reform of building codes, and most importantly—I work across the whole spectrum from hospital to home care, and I can tell you that unless we integrate and seamlessly integrate all these housing and health care opportunities so that people don't

have to fall through the cracks, we're going to lose function and we're going to waste money.

So let's try to look at that and perhaps through managed care—maybe not HMOs—but managed care we can do that.

I'm going to conclude my comments with a quote from Mother Teresa that said, "In India the disease is poverty and in America the disease is loneliness," and I think OBRA went a long way to reduce the loneliness that exists in America's nursing homes.

Thank you.

[The prepared statement of Dr. Russell follows:]

PREPARED STATEMENT OF WILLIAM M. RUSSELL

Dear Mr. Chairman and Members of the Senate Select Committee on Aging, as a Geriatrician and Medical Director, I have been involved in all aspects of long-term care for ten year. I care for 60 long-term care residents at St. Elizabeth Home. I have had significant input into facility planning, design and operations, and have seen many improvements in attitudes and behaviors in that time. My career spans a significant evolution in long-term care from the warehouse for old people to the residence where frail people can live the remainder of their years in peace and dignity. I believe OBRA 87 has been at the core of these changes.

Clearly as hospital length of stay has decreased and frailty and comorbidity have increased, the pressures on the long-term care facilities have been extraordinary. Many facilities are still poorly prepared for the increase in acuity and the overwhelming dependency of the residents. I have had the opportunity to visit a wide range of facilities and am always impressed with how little perspective and individual facility can have on how they are doing. I have seen terrific places who think they are doing poorly, and more often I have seen dreadful places who all-to-often think they are doing just fine.

Let me address the areas where significant improvements have been made in the last 5 years, due in no small part to the enforcement of OBRA 87:

1. *Moral personhood:* In the past there was a significant bias against nursing home residents. This stems from the origins of the nursing home as the almshouse or poorhouse, and the common dictum that if you live a frivolous life you will end up in the poorhouse. There is widespread fear and guilty by families and residents surrounding the placement process. It is as if the nursing home resident is not a fully morale person, i.e., they become second class citizens. We have conquered this attitude by loving our residents and staying faithful to them. We honor their preserved capacity and we support them through their dependencies in a way that allows them to feel whole. This paradigm shift creates the opportunity for personal growth by the resident. This uniquely human technique overcomes unsolvable problems. If any phase of life is characterized by unsolvable problems, it is the evening of life. We must maintain an environment that is permissive to problem solving.

2. *Quality of life:* This is the buzzword of the 90's and I suspect it is unmeasurable. Let me say this: From where I sit people who live in nursing homes are capable of full and enriching life experiences and OBRA helps. What is more important, however, is that residents really aren't looking for "quality of life." In the face of diminished capacity and often chronic pain, what they seek is a sense of being alive. It is a lesson that we all could learn from the heroic residents of nursing homes.

3. *Environment:* We have witnessed in the past 5 years extraordinary advances in the design of facilities to support privacy, autonomy, dignity, and comfort. These design changes can allow for independent dining, unassisted upright toileting and freedom of movement with a minimum of assistive devices. However, these capital improvements are not reimbursed and operators who are paid based on dependencies have no incentive to make these changes. I believe the regulations surrounding new construction such as the interpretation of building codes and the formulate used to calculate capital cost reimbursement should be the target of any reform effort.

4. *Quality of Care:* I ask people to be very skeptical about measures of quality. Allow death rate could for example mean that people are treated inappropriately in order to keep beds filled and that the burden of illness is only propagated. Operators can explain away just about anything in patients with such extensive underlying disease. In addition, the burden of care is increasing. What is clear, however, is that people expect more, and this is a good thing. In the past, families would often take

the first available bed, thinking that it would make little difference where their loved one ended up, or feeling that they had no choice. Now, just as in child care, families will visit, interview staff and travel great distances to find quality long-term care. One family said to me "I knew you were out there, I just had to find you." This change in expectations will guarantee that facilities maintain quality of care, and is a direct result of OBRA 87.

5. *Resident Rights:* Although related to the first point, it is clear that staff now give residents significantly more autonomy and privacy. This is especially true of the frailest people. It was once felt that these folks couldn't appreciate the difference. We now know this to be a self limiting belief.

6. *Physical and Chemical restraint reduction:* We now know that it is safe to untie the elderly. We now know that drugs as behavior management devices are unacceptable. Too many people in the industry desire more latitude in the use of these techniques. Please safeguard the rights and dignity of your constituents and our parents and grandparents. We must never go back to the bad old days. Please keep the current regulations regarding psychotropic medications and restraints intact.

There can be no doubt that OBRA 87 mandates more expensive care for residents. I believe however, that OBRA represents only a minimum standard for long-term care. I do not believe that the documentation required is overly burdensome. The benefits associated with these standards far outweigh the cost. I have often heard staff and administrators complaining bitterly that the paperwork keeps them from patient contact. I suspect there is some degree of truth in that, but it must be said that there are many opportunities for additional patient contact being wasted in every facility. I do not think that removing these regulations will translate into significant increases in staff performance. I think that if we do away with these measures the resultant agitation, hypersomnolence, pressure ulcers, incontinence, fractures, family turmoil and staff turnover will consume substantially more time than we presently spend with these problems.

I had the pleasure of being on the faculty for a HCFA surveyor training course. I have also participated in seven surveys, including a survey under the new guidelines adopted in July 1995. I believe the enforcement has not only been reasonable but productive. We identified significant areas for growth in our own facility and corrected them by closer compliance with OBRA guidelines. I am proud of the improvements in our facility and am indebted to the survey process for helping me to identify them.

I would not weaken the OBRA regulations. I would do more to ensure that patients who are needlessly burdened by medical treatments be given another chance at comfort and dignity. I would scrutinize tube feeding in the same way we have looked at restraints and drug use. Many people are tubed fed solely to access the Medicare skilled benefit or to maximize Medicaid reimbursements. There is perhaps no greater indignity than being fed through a tube in your nose. All these patients become isolated, nonverbal, and often have *decreased* survival.

I truly believe that the nursing home industry needs to be more closely integrated into the health care system. The current system of financing creates an enormous void between independent living and nursing home. There are people who cannot live alone but when living in a well structured and supervised environment they do not require direct nursing care. These assisted living facilities are too costly for average people. We now see that people lose function needlessly and sometimes permanently due to inadequate caregiving and environments. These folks often end up in nursing homes and could have been spared placement but for the presence of an integrated, affordable geriatric care delivery system. We need less "high tech" medicine; we need more "high touch"' caregiving. Please give the American people a managed care system that allows case managers to make these kinds of choices.

When Mother Theresa visited America for the first time she was deeply moved. As she boarded a plan to leave she said "In India the disease is Poverty, in America the disease is Loneliness." As a physician, I have no cure for the diseases that cause people to come to live in nursing homes. My treatments come from a philosophy of care that affirms their moral personhood. This approach produces palpable results. OBRA has done much to advance this paradigm. *We have a long way to go.*

The CHAIRMAN. Thank you very much, Dr. Russell, and the entire panel, let me say to those who are representing the nursing home industry, I tried to make very clear that there are many nursing homes across this country that are doing an outstanding job. That's not what we're here to talk about today but to maintain

the high level of care that we really demand for patients, and to make sure that we have somebody performing oversight.

Mr. Weikel, you indicated you represent an organization or a company that has 150 homes, I assume, spread across the country.

Mr. WEIKEL. That's correct, 16 States.

The CHAIRMAN. Obviously, uniformity is important, uniformity of standards and one would hope uniformity of assessment by those who are making the assessment as to whether there is compliance or not. That's an area that you have raised that we have to look at very carefully in terms of the disparity between a 99 percent non-compliance in one State and a 20 percent non-compliance in another. Obviously, there is something that is not quite right there, but that doesn't mean we shouldn't have the standards. I think you agree with that.

Also, I accept the fact that not every law that we pass is perfect. We may in fact have certain strings, as I mentioned before, that need to be cut. We may need to deal with pass regulations and see if we can't eliminate some of the duplication, and that's something that I'm prepared to do. But I think that overall this law—and I recognize that its providers made the contribution—has been in fact responsible in large part for having these kinds of reductions in physical restraints or improvement in the quality and the assessment of care and maintenance of the ADL functions. These are major improvements and I doubt if you disagree that we have saved and will save the $2 billion by not having to take people out of nursing homes and put them in hospitals.

So there is money to be saved. Obviously, we have to address the issue that we can't insist upon high quality and not also have responsible reimbursement rates. That's something that is a fair issue for you to address.

Part of the difficulty we're facing right now as we go through this debate is that the end game is not in sight. It's an act—I suppose a drama in three parts. One has been the so-called Contract With America and the passage of it, the second is what's taking place on the floor right now in the House and Senate which everyone anticipates is going to be vetoed, and then ultimately we're going to come together and meet some kind of common ground. That's all taking place right now. Unfortunately, it takes a lot of time. For those of you who have been watching C-Span and watching the Senate and House in action, it's the old making of sausages remark of Bismarck. It's time-consuming, not all together pleasant, but necessary in a Democratic society. Ultimately, we will arrive at a consensus, and it's one which will take the agreement of the President and both House and Senate. We will arrive there—not today, not tomorrow but soon.

So your testimony has been helpful. I think that we can address some of the concerns you've raised, but I must reiterate my commitment to maintaining OBRA's standards not only for solvency but quality of care, and that's something that I've got to address right now. I have Senator Chafee waiting on me to talk to me about where we go from this meeting to the debate on the Senate floor.

In any event, thank you for your patience and waiting for us to move to the third panel. Your testimony has been very helpful and it will be taken into account, thank you.

The Committee will stand in adjournment.

[Whereupon, at 12:20 p.m., the committee adjourned, to reconvene at the call of the Chair.]

[Additional material submitted for the record follows:]

APPENDIX

NURSING HOME STANDARDS

This is a very emotional issue. My dear father spent the last few years of his life in a nursing home, so I am so well aware of how important it is to assure quality care in these facilities. We have all heard of instances in which nursing home residents have received substandard and even abusive care. These tragic cases are well-documented and highly-publicized—as they should be. We cannot and should not sweep this problem under the rug.

I believe it is possible for loving, caring people to disagree on whether these facilities should be regulated at the State or Federal level. It is an agonizing issue. In 1987, we decided that the Federal Government should have the predominant role in regulating nursing homes. Republicans and Democrats alike joined together in establishing that. We did so because there was a consensus at that time that the States were not performing adequately in this area.

We are now having another debate on whether the States are ready to take back their authority to regulate nursing homes. There are valid arguments on both sides of this debate. I have never "bought into" the notion that Federal officials are somehow blessed with greater compassion or wisdom than State officials. Yet, neither do I believe we should completely abandon our obligation to oversee the manner in which Federal Medicaid and Medicare funds are expended.

I commend Senator Cohen for convening this hearing. I feel it is appropriate to take a "second look" at this issue.

STATEMENT OF BRUCE C. VLADECK

The Republican budget reconciliation proposals will nave far-reaching effects on the quality of care for the elderly and disabled citizens living in nursing homes. The Federal Government has long had a significant role in financing both home and community-based and institutional long-term care. Of the 1.5 million people living in nursing homes, the majority, 68.5 percent, rely on Medicaid to pay for their nursing home care, while another 5 percent rely on Medicare. We also have an important responsibility in assuring the quality of nursing homes for the increasing frail elderly population who will depend on them for their care. The Republican budget reconciliation proposals could seriously undermine mechanisms to assure quality.

The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987, passed with bi-partisan support during the Reagan Administration, assure nursing home residents of critical rights and protections that ensure quality care in our nation's nursing homes. The Republican proposals could dismantle Federal quality protections and may put elderly and disabled Americans and their families at risk.

NURSING HOME QUALITY AT RISK

Substantial improvements in nursing home quality have been accomplished over a span of two decades. While we still have much to do, the Republican budget reconciliation proposals could dismantle the foundation we have built over time and threaten to reverse our progress to date. Quality of care for all Americans in nursing homes—including parents, grandparents, and severely disabled children and non-elderly adults is seriously jeopardized.

As a researcher and later a member of the Institute of Medicine Committee which studied nursing home regulation in the mid-1980's, I personally witnessed the often deplorable conditions that motivated the Congress to call for Federal quality standards for nursing home care. Cases of abuse and neglect of nursing home residents, as well as scandals involving financial chicanery and political influence, were abundant. The elderly and disabled in nursing homes were often neglected and abused.

The Institute of Medicine study, prompted by a previous call for regulatory reduction by the Reagan Administration, confirmed the very serious problems in nursing home quality and resulted in a bi-partisan commitment to enact more stringent requirements and establish a stronger Federal role in enforcement of those standards. Their findings led to the passage of the OBRA 87 nursing home reform legislation.

OBRA 87 HAS IMPROVED NURSING HOME QUALITY

The OBRA 87 reforms were developed and implemented through a partnership between the State and Federal Governments, providers, and consumers. As a result, quality standards are higher, cases of abuse and neglect are more aggressively pursued, and offending facilities are more often punished. With the implementation of the enforcement regulation on July 1 of this year, the keystone of nursing home reform has become fully operational. Although quality problems still arise, we have made considerable progress in developing an outcomes-oriented quality assessment process that identifies and corrects these problems quickly and reliably. The "sentinel effect" of this system prevents many potential abuses from materializing.

Years ago, quality was reviewed in terms of process, procedure, and structure. Nursing homes were judged on whether they kept good records and whether the facility smelled good. Surveys were largely paper reviews, and what was really going on with patients was of secondary concern. Poor quality nursing homes fixed their problems long enough to come into compliance for surveyors but then slipped out of compliance and back to their old ways. In the absence of the OBRA 87 outcomes-oriented quality measures, it is likely that process-oriented standards would be reinstated.

Today, as a matter of national policy, we insist that residents get the care they need based on an individual assessment. Residents must be treated with respect and dignity and have their independence and privacy ensured. OBRA 87 protects residents against involuntary transfer or discharge from facilities and grants them individual choice in determining the care they receive.

Hard data show that OBRA 87 nursing home standards have improved quality of care. Since the nursing home reform law went into effect, the number of physically or chemically restrained residents has been reduced. Use of physical restraints has declined by at least 50 percent; chemical restraint reduction estimates range from 19 percent to 59 percent. In addition, a study conducted by Research Triangle Institute cited a 25 percent decrease in hospitalization rates with a corresponding decrease in Medicare costs and an increase in residents' functional status from 1990 to 1993 both attributable to nursing home reform.

Clearly, the major reason for these improvements in the quality of care is the reformed Federal system of standards and the enforcement of these standards. This system effectively identifies and sanctions facilities delivering poor quality care.

However, we must continue to be alert. Even with a good quality assessment system, instances of poor quality care arise all the time. For example, since July 1 of this year, in surveys conducted using the newly implemented enforcement system, we have identified cases of abuse and neglect including the following:

In Maryland, a resident was strangled to death by a physical restraint because she was not properly supervised while wearing it.

In Florida, a resident was sexually abused by a nurse's aide.

In Washington, a resident was refused assistance in toileting and told to urinate in her diaper.

In Indiana, a resident was left unsupervised at the top of the stairs. The resident fell down the stairs and was killed.

An effective system of standards and enforcement is a critical safeguard from abuses like these; our system has identified and moved to correct these and similar cases. We are becoming even more effective in identifying and taking action to prevent these cases. Even more important, however, are the cases that never arise because of the existence of this system. Nursing home operators who know that the care they provide is scrutinized by an effective system are doubly careful to insure that abuse and neglect never occur. This "sentinel effect" is also at risk if this system is permitted to deteriorate.

MAJOR PROTECTIONS ARE LOST

The Republican Medicaid block grant proposal repeals the OBRA 87 nursing home standards and permits the States to develop standards "as they deem necessary". These new "health and safety" standards would be enforced entirely at State discretion. The proposals, in other words, repeal an operating, effective system of quality

review, while offering no assurances that whatever replaces it would insure a sufficient level of quality, nor protect residents from abuse and neglect.

Moreover, the proposals eliminate all Federal quality standards for people residing in facilities for people with mental retardation and developmental disabilities, and they make no provision at all for State standards. Individuals in these facilities are often equally, if not more, vulnerable than the elderly in nursing homes.

Critical Federal beneficiary-centered, outcomes-oriented standards would be lost. For example:

- Facilities would no longer be required to provide the range of services (nursing, rehabilitation, social services, pharmaceutical services, dietary services, activities programs) to meet the needs of residents. Cutbacks in these services could seriously diminish residents' quality of life.
- Training and testing of nurse aides, the front-line care givers in nursing homes, would no longer be required. This would be a monumental blow to quality of care. If anything, nurse aide training is needed more now than ever because the severity level of nursing home cases has increased due to earlier hospital discharges.
- Basic Federal requirements for fire safety and infection control could disappear; States would not be required to replace them. This could bring the return of the days when fires and food poisoning in nursing homes were all too frequent.
- Transfer and discharge rights that protect residents from being dumped out on the street could be seriously diminished.
- Nursing home quality of care could take a giant step backwards with elimination of the requirement for resident assessments. The information collected using the resident assessment instrument helps nursing homes to identify each resident's need and develop individualized care plans to meet those needs.

HISTORY INDICATES THAT STATE STANDARDS WILL BE INEFFECTIVE

Before nursing home reform and the advent of revised Federal standards, States were frequently unsuccessful in controlling the quality of care delivered in their nursing homes. Although States may have been *willing*, they were not *able* to successfully develop and enforce nursing home quality standards in the past for both political and financial reasons. Given the significant reductions in Federal Medicaid spending included in the Republican block grant proposals, States' abilities to develop and enforce standards will be more difficult than before.

MEDICARE STANDARDS WOULD ALSO BE WEAKENED

The House Republican budget proposal even undermines uniform Federal standards for Medicare-certified facilities. Under the House plan, facilities are given the choice of being certified under new, weaker Federal standards, or certified by the individual States. Like the Medicaid budget proposals, the revised Federal standards for Medicare significantly weaken existing statutory protections.

Without consistent standards, the quality of care delivered to Medicare beneficiaries could vary by State or even by facility. Thus, the Federal Government would no longer be able to ensure that beneficiaries receiving federally funded Medicare skilled nursing facility services receive comparably high quality care wherever they are served. That is, there could be great variation in the quality of the care provided to Medicare beneficiaries.

THE NEW ENFORCEMENT SYSTEM IS NOT A VIABLE SUBSTITUTE

The proposed enforcement system for Medicare cannot be relied on to maintain quality conditions in nursing homes. Even when residents lives are immediately jeopardized, the proposals give any facility potentially subject to sanctions an opportunity for a hearing and the time to correct its deficiencies before sanctions are imposed. In the past, before the current rules limiting the time before a hearing existed, hearings were sometimes delayed up to a year. Under this proposal, facilities will be allowed to continue to care for people even though they have been identified to have significant care problems. In contrast, the current system places the health and safety of the *residents* above the interests of the *facility*. The Republican budget proposals tear down the current Federal enforcement system and do not replace it with a viable substitute to ensure consistent quality of care.

FURTHER ADVANCEMENT IN QUALITY WILL BE JEOPARDIZED

Over the past several years, HCFA has worked in partnership with industry and consumers on a number of quality improvement initiatives. Uniform data collection requirements included in OBRA 87 serve as the foundation for much of this work.

If the OBRA 87 nursing home reform provisions are repealed, advancement to date and promise for the future will be sacrificed.

For example, HCFA is now implementing a comprehensive approach for developing and using "quality indicators" to improve care and services in nursing homes. Quality indicators are measures of care that have been demonstrated to be predictive of access, care outcomes, or satisfaction. This effort depends on the establishment of a longitudinal data base of resident characteristics and functional status. If the OBRA 87 requirements are repealed, facilities would no longer be required to collect a uniform set of data, and the Federal Government would have to abandon the development of the data base necessary for this innovative quality assurance effort.

In addition, the implementation of an adequate case-mix adjustment factor for a skilled nursing facility prospective payment system also depends on the continued collection of uniform data. Without the data, we will not be able to pay facilities higher amounts for caring for sicker patients, which may jeopardize access for heavy care patients.

We have also initiated an aggressive program of working with States, industry, consumers, and professional group representatives in identifying and disseminating best care practices to nursing homes throughout the nation. For example, we recently disseminated validated procedure on how to provide care to residents with dementia without resorting to tying them up or drugging them. If the Federal role in nursing home quality is diluted, innovation will be hampered. The block grant proposal undermines the Federal Government's key role in this regard.

CONCLUSION

Today, the Federal and State governments work in partnership to ensure quality care for our nation's citizens in nursing homes. By dismantling the current system, the Republican plan sacrifices the substantial improvements in nursing home quality to date, and invites a return to the a time before Federal standards when nursing home residents were often neglected and abused.

As you continue to consider the Republican proposals, I urge you to consider the need for a continued Federal role in setting quality standards and working with States to ensure that they are achieved.

STATEMENT OF STEWART BAINUM, JR.

As the Chairman and Chief Executive Officer of Manor Care, Inc., I want to express our strong support for retention of the Nursing Home Reform Act of 1987 (OBRA 87). Manor Care owns and operates 170 skilled nursing facilities in 28 states, and provides care to over 20,000 residents.

The OBRA 87 reforms represent the most comprehensive revision of nursing home regulations since the inception of the Medicare and Medicaid programs in the sixties: As I recall, the bill was over 1000 pages long, and addressed critical areas of care, such as resident assessment and care planning, nurse aide training and testing, resident rights, nurse staffing ratios, and enforcement. The final product reflected the agreement reached among 60 national organizations, representing consumers, seniors, providers, and state regulators. It was a painstaking process that worked. In fact, OBRA might depict one of the finest collaborative achievements ever in the history of health care legislation.

Manor Care proudly supported OBRA in 1987 because the legislation offered a valuable means of protecting and promoting the quality of life for one of the most vulnerable segments of our population. We must afford nursing home residents an environment which is safe and ensures their physical and mental well-being. OBRA 87 has been widely successful in accomplishing this goal.

Manor Care pledges to continue to meet these Federal quality standards because they are reasonable, and have led to significant improvements in the care delivered to our residents. As a national company, we are supportive of the uniformity and consistency these standards provide across the States.

OBRA created a system of care delivery to help guarantee the dignity and respect of institutionalized seniors. Do not undo the valuable work that has been done. We ask that Congress support retention of the Nursing Home Reform Act and its standards. Stated most simply, it is the right thing to do.

STATEMENT OF AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

The American Health Information Management Association (AHIMA) commends Senator Cohen and the members of the Senate Special Committee on Aging for commencing this hearing on "Nursing Home Quality Care Standards." AHIMA is the professional organization of over 35,000 credentialed health information management professionals. Over 1500 AHIMA members specialize in long-term care and many of these individuals have had the opportunity to witness first-hand the strides that have been made in the quality of life and quality of care provided to residents in nursing homes over the past several years. Our members assist the staff of nursing homes to improve the quality and efficiency of documentation in medical records and to help them understand and implement State, Federal and local regulations as well as professional practice standards. Because of these vast improvements in nursing homes that we attribute directly to the portion of Omnibus Budget Reconciliation Act (OBRA) of 1987 affecting nursing homes, we feel strongly that the Federal nursing home standards enacted in OBRA 1987 should not be repealed as proposed by the current Republican plan to reform Medicaid and Medicare.

Since enactment of the "Nursing Home Quality Care Standards," we have personally witnessed the reduction in the number of nursing home residents being physically restrained. There are estimates that 60–70 percent of nursing home residents were physically restrained prior to OBRA 1987. Less than 20 percent of nursing home residents are currently being physically restrained. That number is still unacceptable but is decreasing as the Federal regulations are being more strictly enforced by state surveyors.

While we believe that most providers of nursing home care in our nation have the resident's best interests at heart, we also understand that there are financial considerations that come into play. These considerations impact the decisions that are made regarding the quality of care and quality of life issues in nursing homes. AHIMA members also witness the response of nursing homes to the enforcement of the Federal regulations. If strict regulations did not exist, it is clear that many providers would continue to physically restrain some residents to avoid having to employ additional staff to walk, care for and watch nursing home residents.

Several of our members have shared stories of their personal experiences. The first is about Walter, a nursing home resident in Cincinnati, Ohio. Walter had a physician's order to wear a waist belt restraint to prevent him from walking unassisted. One day, as the health information management consultant was walking down the hall of the nursing home, she found Walter sliding out of his wheelchair with the waist restraint almost around his neck. It took the health information management consultant several minutes to locate any staff to assist her with Walter. When she finally found a nurse, the nurse's response to the situation was "Oh, Walter, he always does this." The health information management consultant was able to go directly to the Director of Nursing and work on implementing a restraint reduction program that would eliminate this type of inappropriate restraint usage. The support for such a restraint reduction program that this health information management professional was able to implement was found in the Federal regulations.

The second story involves Homer, a resident of a nursing home in rural Ohio. Homer had been a farmer all of his life and was very distressed to find himself confined to a nursing home. He had been in the nursing home for several months and expressed to the health information management consultant of the facility that he just could not get used to being inside all of the time in the air conditioning. Homer explained that he had an alarm around his ankle that sounded whenever he went outside. He promised anyone that would listen that he would not run away. He just wanted to go outside. The staff never seemed to have time to take Homer outside. They would not let him go alone, as they were afraid he would wander into the woods and get lost. In working with the administration of the facility, the health information management consultant was able to direct their attention to the quality of life Federal regulations as well as the physical restraint Federal regulations and worked with them to have a fence installed around a large courtyard area that enabled residents, including Homer, to move about freely without alarms or constant staff vigilance.

These are just two examples that describe how the Federal regulations have made a positive impact on the lives of nursing home residents. There are literally thousands of stories like this. We have witnessed improvements in the quality of the lives of nursing home residents as well as the quality of care. There has been a decrease in the use of in-dwelling catheters, an increase in the use of restorative care, a decrease in the number of pressure ulcers, an increase in the use of behavior management programs, and many other positive results.

At AHIMA, we are also aware of research that has been reported by the Research Triangle Institute, a non-profit research arm of the University of North Carolina, Duke University, and North Carolina State University. The Research Triangle Institute estimates that $2 billion a year in Medicaid funds have been saved as a result of the nursing home standards enacted in OBRA 1987. These savings will become a loss if the Federal standards are repealed as proposed by the current plan to reform Medicaid. The quality of care and the quality of life for nursing home residents will decline and the number of hospitalizations to acute care facilities will increase if the standards are eliminated. We have already witnessed an improvement in the quality of life of nursing home residents as facility administration and staff respond to the new survey process that was implemented on July 1, 1995. This new survey process places more of an emphasis on the quality of life in nursing homes.

As health information management professionals in long-term care and as consumers of health care, we would like to believe that the lives of nursing home residents would not change with a repeal of the Federal regulations for nursing homes, but we know better. We witness, on a daily basis, how nursing home staff respond to Federal regulations. Unfortunately, many times it is only because of the regulations and nothing else that there is an improvement in the quality of life and quality of care for nursing home residents.

AHIMA would like to take this opportunity to thank you, Senator Cohen, and the Senate Special Committee on Aging for holding this hearing and allowing AHIMA to submit written testimony on the "Nursing Home Quality Care Standards." If you or your staff require additional information, please do not hesitate to contact Kathleen A. Frawley, JD, MS, RRA, Director, Washington, DC Office of the American Health Information Management Association.

Prepared by HCFA

Nursing Home Enforcement
Monitoring Summary

OBRA '87 legislation raised the standards for nursing home care and at the same time increased reimbursement to nursing homes to reflect the cost of compliance with these new standards. These higher standards have been in effect since October 1, 1990. The system to enforce these standards took effect on July 1, 1995. During the first year of enforcement, many nursing homes will be cited for not meeting these standards, as they adjust to these new expectations. With this in mind we developed an enforcement system that gives the vast majority of nursing homes a second chance to avoid fines and other remedies by correcting their deficiencies within a set period of time.

The enforcement process is designed to bring about changes in poor practices of nursing homes without requiring that they close or that their residents move elsewhere. For the first time federal and state enforcement agencies are able to choose the remedy that best suits the seriousness of the situation - from civil money penalties, temporary management, directed plans of correction and in-service training to termination. The enforcement process, including the definitions for the scope and severity of harm to residents, was developed in partnership with provider and beneficiary groups.

We have been closely monitoring the implementation of the survey and enforcement process that took effect on July 1, 1995. Following is a summary of key points about the enforcement process.

- Facilities that are not chronic poor performers or that have not placed residents in immediate jeopardy but are found substantially out of compliance with requirements are given up to 90 days to correct the deficiency and to come into compliance. Although survey agencies propose remedies for these facilities, many will correct the problems before the penalties are imposed. As of September 15, 73 percent of the 2520 facilities surveyed were found out of compliance. However, of the 148 facilities rechecked so far, over 92 percent were able to achieve compliance, therefore incurring no fines or other remedies. This is testimony to the philosophy behind OBRA 87: the nursing homes will improve care by complying with standards when required to do so by a strong enforcement program.

- Immediate jeopardy is declared only in the most extreme cases--when immediate corrective action is necessary because the provider's performance has caused, or is likely to cause, serious injury, harm, or death to a resident receiving care in a facility. We feel that instituting immediate sanctions against such a facility is essential to protect resident health and safety.

  Another category of providers which warrant the imposition of a remedy without a prior opportunity to correct are chronic poor performers - those nursing homes which year in and year out have had major deficiencies and provide poor care. Only fines and other serious sanctions are likely to improve care in these facilities.

  Since July 1, 83 facilities or 3 percent have fallen into these categories.

- OBRA '87 provides for an additional designation of substandard quality of care. Currently about 18 percent of facilities fall into this category. Substandard quality of care is defined as a deficiency in quality of care, quality of life, or resident behavior and facility practice that is deemed to have caused actual harm to at least a group of residents or has the potential to cause actual harm on a widespread basis in the facility. Our review of state agencies' determinations indicates that they are accurately interpreting the regulations.

Attached are actual examples of facility practices that have resulted in findings of immediate jeopardy, substandard quality of care, and non-compliance.

EXAMPLES OF FACILITY PRACTICE
SUMMARY

I. IMMEDIATE JEOPARDY

- Maryland- A resident expired due to strangulation from a Posey restraint, because the resident was not properly supervised while wearing the restraint.
- Ohio- A resident expired on 7/22/95 due to strangulation from a vest-style restraint that was incorrectly applied.
- New Hampshire - On 7/25/95, an abusive nurse's aide yelled at a resident and refused to allow the resident to eat her meal.
- Florida- A resident was sexually assaulted by a nurse's aide.
- Indiana - Resident found with maggots in wound.
- Ohio - Resident being fed with syringe aspirated. Staff was unaware of what to do, resident cyanotic and was hospitalized.
- Ohio - Resident left unattended in geri-walker, fell over, injured head and required hospitalization.
- Texas - Resident "force fed" with a syringe aspirated and hospitalized.
- Maine - Widespread development of pressure sores in facility.
- Indiana - Resident left unsupervised at the top of the stairs. Fell down the stairs and was killed.
- Indiana - Resident in respiratory distress left unattended for up to 7 hours. Resident died.
- North Carolina - Resident required thickening liquids to prevent choking. Not provided and resident developed aspiration pneumonia.
- Hawaii - Repeated intimidation, physical and verbal abuse of residents. Administration failed to investigate and intervene.
- Indiana - Resident missing from facility, found 2 blocks away.

II. NOT IN SUBSTANTIAL COMPLIANCE, BUT WITH AN OPPORTUNITY TO ACHIEVE COMPLIANCE AND AVOID A FINE OR OTHER REMEDY.

- Washington- Resident told to urinate in diaper.
- Texas- Residents suffer extreme heat and lack of hydration.
- South Dakota- Residents not provided enough food, losing weight.
- Nebraska- Residents suffer dehydration for lack of adequate fluid intake.
- Texas- Failed to provide care in a dignified manner.
- Washington - Use of restraints and lack of services incapacitates residents.
- Washington - Residents not receiving care to keep them as independent as possible.
- Nebraska- Residents develop infections and bedsores.
- Connecticut - Helpless women residents forced to expose themselves
- Colorado - Resident develops pressure sores in the facility and staff fail to give needed care.
- Montana - Residents suffer severe weight loss, and facility staff fail to provide assistance with meals.

ALL OF THE ABOVE CITATIONS ALSO REPRESENT EXAMPLES OF SUBSTANDARD QUALITY OF CARE

- Nebraska - Residents not given appropriate treatment to maintain their abilities to remain continent.
- Montana - Failure to provide sufficient nursing services.
- Idaho - Residents not being seen timely by a physician.
- Washington - Failure to store, prepare, serve foods correctly.
- Nebraska - Widespread failure to prevent spread of infections.
- Nebraska - Medication errors.

ABSTRACTS

I. IMMEDIATE JEOPARDY

- Maryland - A resident expired due to strangulation from a Posey restraint, because the resident was not properly supervised while wearing the restraint.

  A resident was placed in a Posey vest restraint, and the table top was put across the chair at 6:00 a.m. At 7:00 to 7:30 a.m., the resident was agitated and hollering. At 8:00 a.m., the resident was discovered with her head under the table top and her legs sprawled on the floor. The resident's arms were up over her head and the Posey restraint was around her neck. Her body color was yellow and grey. The resident was declared dead. Throughout the facility restraints were ordered for such reasons as stealing cigarettes from one another, leaving the grounds of the facility, and falls. The residents who were restrained to prevent falls continued to have falls with the restraints in place.

- Ohio - A resident expired on 07/22/95 due to strangulation from a vest-style restraint that was incorrectly applied.

  A resident was found 07/18/95 with a vest restraint tied around the neck and chest. The resident was cyanotic, had no vital signs, no pulse, and no respirations. CPR was started, and the resident was sent to the hospital. The resident expired in the hospital on 07/22/95. During the investigation, it was determined that the facility used a medium-sized restraint when the manufacturer's directions for this resident indicated the use of a small-sized restraint. Restraints were applied without assessments for their use and without physician's orders.

- New Hampshire - 07/25/95, an abusive nurse's aide yelled at resident and refused to allow the resident to eat her meal.

  During the survey of 07/25/95, certified nurse's aide told a resident to "shut up" and leave the dining room. The resident was not allowed to eat her meal and was not offered any other food until the evening meal. The group interview revealed that staff members ignore requests about care, leave disabled people at risk by leaving them in the bathroom alone for over one-half hour and delay residents from leisure time activities. Group interviews also stated that aides tell them to "shut up" and that staff are "rude" and are told to "wait - that they are not the only ones."

- Florida - A resident was sexually assaulted by a nurse's aide.

  A resident was sexually assaulted and found bruised and bleeding by a nurse assistant. Another resident had an attempted assault by the same perpetrator, but was unharmed. Ten other residents has multiple bruises and skin tears as a result of nursing assistants transferring, lifting, or pulling up the residents in bed.

- Indiana- Resident found with maggots in wound.

  During a July investigation involving a resident who was hospitalized because of maggots and larvae in a foot wound, facility staff acknowledged that the facility does not "always have enough staff to give baths" or to maintain the facility. Although the facility had been notified during March that their screens needed to be repaired to prevent flies and pests from entering the facility, the screens were still in disrepair in July.

- Ohio- Resident being fed with syringe aspirated. Staff was unaware of what to do, resident cyanotic and was hospitalized.

  A resident being fed by a nursing assistance had raspy labored breathing and made gurgling sounds indicating the resident needed suctioning. Nurse attempted to suction the resident but did not know how to use suctioning equipment. Surveyor instructed nurse how to use suction equipment. Resident sent to hospital.

- Ohio-Resident left unattended in geri-walker, fell over, injured head and required hospitalization.

  A resident was agitated in a ger-walker and yelling for help. The surveyor found the resident upside down with head on the floor, feet in the air and bleeding from the head. The resident was sent to the hospital with laceration on the forehead.

- Texas- Resident "force fed" with a syringe aspirated and hospitalized.

  A mentally retarded resident was being "force fed." resident was placed in a "head lock" to feed him and was told "drink this." The resident aspirated milk and became cyanotic. Neither the nurse aide or the LVN on duty knew how to operated the suction machine. The physician arrived and told the staff the resident had aspirated something and ordered the resident hospitalized.

- Maine- Widespread development of pressure sores in facility.

  For 12 residents with pressure sores, all 12 had developed the sores in the facility. For 10 of these, the development of the pressure sores was found to be avoidable. Surveyors, found residents were not being repositioned. some pressure sores were at a serious stage, and staff were unaware of some of these sores. One resident was admitted to the hospital for a skin graft for a pressure sore that had progressed without proper treatment.

- Indiana- Resident left unsupervised at the top of the stairs.

  At 6:50 am a resident was left unsupervised by nurses' station on the second floor. Staff thought he was "dozing." Staff report they heard a loud "crash" and when they investigated, the resident was found at the bottom of the stairs with the wheelchair on top of body. Blood pressure was reported as 140/60, but there was no respirations. By 7:00

am there were no vital signs. The resident's body was removed from the facility by the coroner at 8:45 am.

- Indiana- Resident in respiratory distress left unattended for up to 7 hours. Resident died.

Resident had tracheostomy, was dependent on oxygen, needed hand held aerosol treatment with Proventil every 4 hours. Resident was cognitively clear, able to make decisions, cooperative. Resident was found slumped over side rail of bed, no respirations, oxygen tank empty. No MD orders on how frequently oxygen saturations were to be done. No policy and procedures to address the frequency of this procedure. Resident was to receive respiratory assessments every 4 hours. On the day of death, there was a seven hour period with no respiratory assessment.

- North Carolina- Resident required thickening liquids to prevent choking. Not provided and resident developed aspiration pneumonia.

Resident noted to be "coughing on thin liquids." Fluoroscopy indicated "trace aspiration during coughing with thin liquids." Recommendation by therapist to place resident on thickening liquids. No record of thickening liquids could be found. Physician ordered a chest x-ray and diagnosed the resident as having "mild aspiration pneumonia and hiatal hernia."

- Hawaii- Repeated intimidation, physical and verbal abuse of residents. Administration failed to investigate and intervene.

Residents and families reported to surveyors that the staff was rude, used offensive language, and sought to intimidate residents. Residents complained of "rough treatment" by staff and reported that they were "handled abruptly." Facility policies required all complaints of abuse to be investigated. No record of any investigation could be produced and no action had been taken by administration despite repeated complaints by residents and families.

- Indiana- Resident missing from facility, found 2 blocks away.

Group interview revealed this incident which was then corroborated from the resident's chart. There was no incident report or investigation of the event. No care planning to deal with resident's tendency to leave. Two days later, resident again left. Facility again did no investigation.

II. NOT IN SUBSTANTIAL COMPLIANCE, BUT WITH AN OPPORTUNITY TO ACHIEVE COMPLIANCE AND AVOID A FINE OR OTHER REMEDY.

- Washington - Resident told to urinate in diaper.

  A resident about to receive therapy indicated a need to use the toilet and was told by the therapist ":you can pee in the Attends." During different observations surveyors observed staff talking in a demeaning manner in the presence of other residents. For example one nurse aide, while correcting another aide's feeding techniques, said of the resident "well, she's on her way out, anyway," another nurse aide referred to a resident as "combative" but another resident said, "no she was angry."

- Texas - Resident suffers extreme heat and lack of hydration.

  A resident was sent to the hospital in heat distress due to lack of hydration. There were not enough staff members to implement hydration programs (they were not given water and other liquids to drink) when the air-conditioning systems broke down. Eventually residents had to be evacuated because of suffering extreme heat (changes in vital signs and increased body temperatures) for an excessive period of time and the current plan was inadequate to meet their needs.

- South Dakota - Residents not provided enough food, losing weight.

  Residents were not provided with enough food and are losing weight. Residents on pureed diets did not receive correct portion size and lost weight. One resident lost 16 lbs. and now weigh 75 lbs. The lack of snacks and supplements contributed to this wight loss.

- Nebraska - Residents suffer dehydration for lack of adequate fluid intake.

  5 of 5 sampled dependent residents with dementia were not provided with sufficient fluid intake to maintain proper hydration and health. One resident's medical record revealed a diagnoses of dehydration, constipation. Alzheimer's disease with dementia and was aphasic. Resident's care plan stated staff was to encourage liquids at meals and at bedside due to moderate risk of breakdown. Resident has had several infections since admitted. Initial comprehensive resident assessment revealed resident had not consumed all liquids during last three days; however, resident assessment protocols did not address hydration. The records also indicated that the resident's record indicated that the resident's spouse expressed concern over resident not receiving adequate fluids. Throughout the survey, the resident was noted to have dry tongue and mouth. In addition, the resident's medication review revealed resident to be taking Lasix which has a side effect of dehydration.

- Texas - Failed to provide care in a dignified manner.

  Facility failed to provide care in a dignified manner to three of three confined Total Care

Residents that were showered by facility staff. Resident #1 was placed by a CNA on a shower cart that was not large enough to accommodate the resident's full body and therefore had to be placed in a fetal position. The CNA proceeded to shower the resident without first checking the water

- Washington - Use of restraints and lack of services incapacitates residents.

Staff failure to provide the necessary exercises and services resulted in 6 residents who have marked decline in their abilities to walk, transfer, or move in wheelchairs, and in addition to increase in contracture. One of the residents who had been able to walk independently but who had been restrained and had not been allowed to walk now required assistance. Another resident who had received physical therapy after repair of a hip fracture, was discharged from therapy in mid July and by the August survey had already lost some ability to walk. A resident who was supposed to be getting exercises 3-5 times a week only received exercises 5 times in July and was unable to stand and bear weight.

- Washington - Resident not receiving care to keep independent.

Based on observations, interview, and record review, it was determined that 6 of 21 sampled residents were not provided adequate bathing, dressing, grooming, transfer, and /or ambulation to meet their needs. Referral to restorative nursing programs did not occur as they were needed by the residents, residents were not walked or provided care to keep them as independent as possible. All six residents were not provided with services that would ensure that they reach their highest practicable level of functioning in the above areas listed.

- Nebraska - Residents develop infections and bedsores.

The facility failed to provide the necessary treatment, prevent infections, and prevent new pressure sores from developing in 2 of 4 residents. One resident entered the facility with 2 Methicillin Resistant Staph Aureus (MRSA) infected stage IV pressure sores. This resident was observed sitting in stool and the dressings covering the pressure sores were soiled with stool. On 2 days of the survey, the resident sat either in bed or titled backwards in a lounge chair with unrelieved pressure to the coccyx and buttocks area for periods exceeding 2 hours at a time.

- Connecticut - Helpless women residents forced to expose themselves.

In two blatant examples of a nursing home's lack of regard for the individual's right to privacy, surveyors identified situations where the facility staff exposed dependent residents to onlookers' without providing for their modesty. In the first example, a resident sat in a recliner chair with her perianal area exposed to the view of a male visitor in the room. A nurse entered and left the room without taking any action to cover the resident. In another room, two nursing aides placed a woman on the toilet in full view of her roommate. No consideration was shown for either of these women's' privacy.

- Colorado- Resident develops pressure sores in the facility, an staff fail to give needed care.

  A totally dependent woman developed pressure sores on her right heel and ankle. In July, surveyors noted she did not receive either the amount of food of the mineral supplement that was ordered. The nursing staff improperly did the dressing changes, and she was left lying in the same position, without the needed pressure-reducing devices, hour after hour, further contributing to the breakdown of her flesh.

- Montana- Residents suffer severe weight loss, and facility staff fail to provide assistance with meals.

  Two residents were noted to have had unplanned weight losses. One, whose ideal body weight was from 99-121 pounds, lost 22 pounds between February and April, 1995 and weighed only 92 pounds. Until July, she was still receiving small portions of food instead of the regular size portions she needed. Three of three meal observations revealed that facility staff did not assist her with her meals, and she was not able to eat her food unassisted. Additionally, snacks were not offered her in the evening as they were supposed to have been. The second resident's weight dropped to 85 pounds, reflecting a loss of 11 pounds. He was not encouraged to eat in three of three meals observed, and by the time they passed his evening snack, he was asleep. His serum protein levels were below normal reflecting long-standing nutritional deficits.

- Nebraska-Residents not given appropriate treatment to maintain their abilities to remain continent.

  In the case of one resident, he became incontinent because facility was using an incontinence brief instead of assisting him to the toilet. His past history showed him to be continent. There were similar findings for other residents.

- Montana-Failure to provide sufficient nursing services.

  Based on observation, staff interviews, and record reviews, the facility failed to meet sufficient nursing services for 13 of 15 residents. Nurse aides were not supervised and did not insure that the care plans were executed. Long waits for call lights and basic services such as oral care, washing hands and faces and perineal care were noted.

- Idaho-Residents not being seen timely by a physician.

  The facility failed to insure that 10 of 17 residents were seen in the required time frames by their physician. One resident had no visits by a physician for 4 months. Another was admitted 12/28/94. She was seen two times in the first 90 days (1/13 and 3/5), but was not seen again until 6/5/95.

- Washington- Failure to store, prepare, serve foods correctly.

Potentially hazardous foods were not held at or above 140 degrees to prevent the potential growth of food borne illness causing bacteria. In additions, canned items were not adequately checked for abnormalities and food items were not covered when distributed.

- Nebraska- Widespread failure to prevent spread of infections.

It was observed that staff did not wash their hands and/or change gloves after direct resident contact. Staff did not wear gloves as a universal precaution against exposure to body fluids. Staff were observed touching residents and then walking to the central linen room without washing their hands before handling new linens. In addition, staff were observed using ungloved hands to hold gauze dressings next to an infected pressure sore, flushing the sore with saline, resulting in the fluid running across the wound into the gauze and into direct contact with staff members' hands.

- Nebraska- Medication error rate over 10%.

There were 5 medication errors out of 44 observed drugs passed. In 2 cases, residents were not given specific drugs because they were not available. Another resident had Paxil prescribed at bedtime and received it at 8:50 a.m. The nurse stated the medication was given at the wrong time.

Testimony from the Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of HealthCare Organizations (JCAHO) is a private, not for profit organization that is the nation's leading accreditor of health care facilities. In 1995 the JCAHO evaluated more than 15,000 health care organizations within a number of program areas, such as hospital care, ambulatory surgery, home health, hospice, laboratories, managed care organizations, mental health and substance abuse programs, and long-term care services. The Joint Commission has been at the forefront of quality standards for nursing homes since 1966 when it began its accreditation program for long-term care organizations. The Joint Commission currently accredits more than 1500 long-term care organizations across the country, and provides special accreditation certificates for subacute care program and dementia special care units. By 1996 the Joint Commission will also accredit long-term care pharmacy services.

Accreditation is a private, voluntary program that sets forth optimal achievable standards to organizations wishing to attain special recognition for the level of quality care that they provide patients and residents. The standards exceed those of the Health Care Financing Administration's (HCFA) conditions of participation based on the Omnibus Budget Reconciliation Act of 1987, and apply the most state-of-the-art standards currently available to long-term care organizations. Our standards are constantly reviewed and updated by a broad representation of professional association, government and consumer groups, and other experts that advise the Joint Commission on standards development and survey procedures. The list of members in this professional and technical advisory committee are at Attachment A. Joint Commission standards are patient centered and move beyond assessing the simple existence of process and procedures to an evaluation of actual performance. The Joint Commission survey makes a determination of how well critical care processes are actually carried out and whether the nursing home is continually improving its performance in key functions related to patient care. A full listing of these functions is found at Attachment B.

In addition to having the most comprehensive and modern nursing home standards, the Joint Commission's long-term care surveyors are the best trained cadre of nursing home surveyors in the world. Each surveyor has at least 5 year's experience as a director of nursing or as an administrator of a long-term care facility. Our surveyors average more than 15 years experience in long-term care and are well educated; most being master's prepared. Consequently, JCAHO surveyors can provide unparalleled consultation and education as a primary part of the survey process. This is extremely important, because as a country, we should be about improving all facilities, not just those which provide substandard care.

Nursing homes seek accreditation for many reasons. The most important reason is that accreditation improves overall care, and enhances public confidence. Accreditation stimulates organizational performance improvement and demonstrates to residents and families the organization's commitment to providing high quality services. This in turns enhances community confidence that the nursing home is willing to take extra measures to ensure that it continually improves its processes and stretches itself to meet the highest possible industry standards. A second important reason that nursing homes aspire to accreditation is their desire to provide professional education to staff and to promote staff morale. A third reason is bench marking. Accreditation helps the organization measure itself against objective national standards that are consistently applied. Therefore, accreditation is used as a nationally recognized benchmark of quality to attract professional referrals, insurers, and major employers.

Further, accredited facilities must agree to release performance reports, that are available to the public, about the quality of care in their organizations. This disclosure represents the Joint Commission's commitment to public disclosure and to the belief that consumers need and want detailed quality information in order to make informed choices about health care. The Joint Commission has also taken the leadership in the area of developing outcome indicators for clinical care, and is in the process of developing reporting systems for all types of health care organizations that are accredited. Our accreditation programs are cutting edge, and, in the case of long-term care, are implemented at less than half the price of a HCFA survey.

No external review organization for nursing homes stands for higher standards than the Joint Commission on Accreditation of HealthCare Organizations. However, as the leading standard setting organization in this and other areas, we are troubled by the lack of a public/private partnership in the area of quality monitoring for nursing homes. Despite the clear value of private sector accreditation, there has been no recognition by the Federal Government of its merit, nor permission granted

by the Health Care Financing Administration to States wishing to cost effectively use their oversight resources by recognizing accreditation for Medicaid purposes. We believe that this failure represents public dollars misspent.

With limited resources in nearly every sphere of government spending, we should carefully examine each expenditure and be open to ways that will stretch the reach of the taxpayer dollar. We are not advocating a reduced budget for nursing home surveys, but rather a sensible reallocation to ensure a more effective oversight program with available resources. Every dollar unnecessarily spent by the government routinely inspecting accredited nursing homes, takes away money that should be made available to monitor and improve the poorest performing facilities. We also believe that an enforcement system should not be comprised only of sanctions, and be devoid of incentives for going beyond government expectations of quality. Failure to recognize private sector accreditation for nursing homes takes away an important reward for achieving a special status. This is a counterproductive policy that should be changed.

A number of States have expressed serious interest in redistributing their scare inspection resources, both in terms of dollars and survey personnel, to better focus on problem nursing homes. These States would like to reduce oversight in their Joint Commission accredited facilities as a means of more sensibly using these resources for more productive monitoring. However, this has not been possible to date. As an example, the State of Arizona requested a waiver from HCFA to accomplish such a demonstration. Arizona wishes to recognize accreditation for up to the top 20 percent of their nursing homes; organizations that, in addition to being accredited, have also passed comprehensive screens by the State as to their quality history and their projected compliance with State and Federal regulations. This proposal languishes in HCFA, and will probably not be approved after nearly 2 years of effort on the part of the State. We believe that this is irrational.

A true partnership between private sector accreditation and government regulators could play to the strengths of both programs. Regulators are needed to deal effectively with nursing homes that cannot, or will not, meet accepted standards of practice. The government is the appropriate party to sanction or remove the worst performers from public programs of reimbursement. Accreditors, however, can contribute significantly to the partnership. First, they can encourage more nursing homes to meet higher quality standards by holding out some regulatory relief from extra government inspection that do not add value to the accreditation survey. Second, accreditation can reduce the demand on the government's limited resources by reducing the overall number of facilities that must be inspected in any given year.

Third, the inspections gained by the government are done by the highest caliber surveyors and are performed at no cost to the government.

We value our existing partnership arrangements with HCFA in the many areas in which we currently share health care evaluation—such as for hospitals, laboratories, and home health—and believe that these arrangements provide a model for extending that partnership to long-term care facilities. The appropriate roles for both government and the private sector in long-term care quality should be carefully examined and evaluated, especially now when we are grappling with complex issues of quality, cost, and consumer confidence. At minimum, we would like the Committee to consider requiring a HCFA demonstration to address the best use of accreditation by government. Accreditation holds vast benefits to those nursing homes that can achieve it, to the residents of those facilities, and to the taxpayer who will see a better use of Federal/State survey budgets. Use of accreditation is a win-win situation for all involved, and should be evaluated by those who are stewards of the public trust and purse.

As in the past, the Joint Commission on Accreditation of HealthCare Organizations stands as a resource to government. We are happy to share our standards and our survey expertise in any way the committee, the States, or the Department of Health and Human Services view as helpful to them or to the public.

ATTACHMENT A

THE PROFESSIONAL AND TECHNICAL ADVISORY COMMITTEE
TO
THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE
ORGANIZATIONS' LONG TERM CARE PROGRAM

* ALZHEIMER'S ASSOCIATION
* AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
* AMERICAN ASSOCIATION OF HOMES FOR THE AGING
* AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS
* AMERICAN COLLEGE OF PHYSICIANS
* AMERICAN DENTAL ASSOCIATION
* AMERICAN GERIATRICS SOCIETY
* AMERICAN HEALTH CARE ASSOCIATION
* AMERICAN HOSPITAL ASSOCIATION
* AMERICAN MEDICAL ASSOCIATION
* AMERICAN NURSES ASSOCIATION
* AMERICAN SOCIETY OF CONSULTANT PHARMACISTS
* COALITION OF REHABILITATION THERAPY ORGANIZATION
* HEALTH CARE FINANCING ADMINISTRATION
* NATIONAL ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION IN LONG TERM CARE
* NATIONAL ASSOCIATION OF SOCIAL WORKERS
* PUBLIC MEMBER
* SUBACUTE COALITION
* VETERANS ADMINISTRATION
* CHRONIC DISEASE HOSPITAL - AT LARGE MEMBER

ATTACHMENT B

1996 LONG TERM CARE FUNCTIONS

* RESIDENT RIGHTS AND ORGANIZATION ETHICS
* CONTINUUM OF CARE
* ASSESSMENT OF RESIDENTS
* CARE AND TREATMENT OF RESIDENTS
* EDUCATION OF RESIDENTS
* IMPROVING ORGANIZATION PERFORMANCE
* LEADERSHIP
* MANAGEMENT OF THE ENVIRONMENT OF CARE
* MANAGEMENT OF HUMAN RESOURCES
* MANAGEMENT OF INFORMATION
* SURVEILLANCE, PREVENTION, AND CONTROL OF INFECTION

STATEMENT OF JOHN H. PICKERING ON BEHALF OF THE AMERICAN BAR ASSOCIATION

Mr. Chairman and Members of the Committee: I appreciate the opportunity to present the views of the American Bar Association on nursing home quality care standards. I am John H. Pickering, Chair of the American Bar Association's Commission on Legal Problems of the Elderly. The ABA is extremely concerned about provisions of both the House and Senate Medicare reform bills that will effectively eliminate current Federal nursing home quality standards and enforcement requirements. We believe such action will seriously undermine the ability of residents of nursing homes to be assured of receiving quality care.

Current Federal standards, enforcement mechanisms and oversight of nursing home care should be retained. These mechanisms can and should be retained under a block grant, cost-sharing or other program reform structure.

Portions of the Medicare bill approved by the Senate Finance Committee September 29, 1995, and Section 15526 of Subtitle F of H.R. 2425, as passed the House, would eradicate 25 years of slow but steady progress in improving the lot of the nation's most vulnerable citizens who live in America's almost 16,000 nursing homes. Recurring nursing home scandals and congressional hearings in the 70's and 80's documented the States' failure to correct demeaning, unsafe and even life-threatening conditions that many of our 1.8 million nursing home residents endured. In 1986, the prestigious Institute of Medicine (IOM) issued a national blueprint for change, *Improving the Quality of Care in Nursing Homes.* As to the necessity of Federal involvement in the enforcement of quality of care standards, the IOM concluded:

> [M]ore effective government regulation can achieve substantial improvement in quality of care in many nursing homes in all States. A stronger Federal leadership role is essential for improving nursing home regulation because not all State governments have been willing to regulate nursing homes adequately unless required to do so by the Federal Government. (p. 21–22)

In response, Congress enacted the 1987 Nursing Home Reform Amendments using the IOM report as its blueprint. The law is common sense regulation, based on the needs of individual residents. The key elements of the Nursing Home Reform Act include:

- Individualized assessment of each resident's abilities and needs.
- A plan of care, with specific goals, methods and measurements addressing residents' needs.
- A standard of care that supports the physical, mental and psychosocial wellbeing of each resident through supportive care, therapy, and resident and family participation.
- A standard of quality of life for each resident that provides for reasonable accommodation of individual needs and preferences.
- Protection of residents' rights to dignity and security, and freedom from abuse, restraints, and involuntary transfers and discharges.
- Training for nurse aides who deliver 90 percent of the care and attention to residents.
- Resident access to the long-term care ombudsman program for assistance when problems arise.
- Enforcement of standards through effective survey procedures that review the care from the resident's point of view, identify problems, assure correction and apply appropriate penalties.

The reforms have been phased in over a period of years. As implementation and enforcement have proceeded, the quality of care began to rise. For example, the use of unnecessary, and often dangerous, physical restraints has declined dramatically; meaningful activities and trained staff now keep residents safe without tying them up. Hospital use by nursing home residents has decreased, resulting in reduced health care costs.

The last phase of implementation, enforcement against homes that do not voluntarily comply, began this past July. Now, through efforts to reduce the budget and address the spiraling costs of Medicaid and Medicare, the Congress is on the verge of doing away with this law and undermining the prospects for a decent quality of life for nursing home resident in this country.

The threat to nursing home quality takes five forms:

- Repeal of the standards for nursing home quality. The States would be permitted to create their own nursing home facility certification standards. In the alternative, facilities would have to meet standards set by the Federal Government. However, the bill specifies only a brief list of resident rights. The current statutory

standards regarding quality of care, quality of life. care planning, staffing, and training would be eliminated.

• Elimination of required enforcement tools, such as fines, bans on new admissions, and other "intermediate" sanctions that just took final effect on July 1, 1995. These would be permitted but not required under the bill.

• Cuts in Federal payments for care, which in turn are likely to result in reduced state budgets for inspection of nursing homes and enforcement actions.

• Cuts in funds for the Long-Term Care Ombudsman and Legal Services programs that represent people in nursing homes who encounter problems.

• Proposals in H.R. 2425 to restrict the rights of all consumers to be compensated for injuries resulting from medical malpractice. Nursing home tort litigation is unique. It generally provides little or nothing in the way of compensatory damages. Only cases that merit pain and suffering awards or punitive damage awards are likely to be pursued. If current proposals to restrict medical malpractice recoveries are enacted, residents will face double jeopardy—weakened regulation aimed at preventing poor care and less access to legal redress when wrongful injury has occurred.

If Federal leadership in setting quality standards and enforcement is eliminated, progress in improving the lives of nursing home residents can be expected to falter and, indeed, revert to the lowest common denominator. For the sake of hundreds of thousands of our most vulnerable citizens, we must not allow this to happen.

Since 1983, the ABA has supported "the retention of effective enforcement mechanisms to ensure adequate quality of care in nursing homes participating in the Medicare and Medicaid programs * * *.". That policy was adopted in response to executive branch proposals to dilute the conditions of participation for nursing homes at that time. In 1989, the ABA further adopted a policy supporting "the enactment of Federal and State legislation providing a coordinated and comprehensive system of care and support for Americans of all ages with long-term care needs." The following language from that policy also endorses the quality principles detailed in the IOM report:

> Any system of long-term care should * * * Assure appropriate quality consistent with the principles recommended by the Institute of Medicine for nursing home care. * * *

In conclusion, current Federal standards, enforcement mechanisms and oversight of nursing home care should be retained as part of both Medicare and Medicaid reform. These enforcement mechanisms can and should be retained under a block grant, cost sharing, or any other program reform structure. The obligation of the Federal Government to watch out for the nation's most vulnerable citizens must be taken seriously.

Thank you for giving us this opportunity to submit our views to you.

STATEMENT OF THE AMERICAN SOCIETY OF CONSULTANT PHARMACISTS

Mr. Chairman, thank you for allowing the American Society of Consultant Pharmacists (ASCP) the opportunity to submit our statement for the record. As part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), Congress enacted Federal nursing home standards to remedy numerous abuses and lapses in patient care that resulted from inadequate state oversight. Repeal of those standards would eliminate many patient protections—including safeguards against medication errors, the use of unnecessary drugs and the inappropriate use of antipsychotic drugs—that are particularly important for assuring the well-being of the frail, institutionalized elderly. We commend you, and the members of this committee, for holding this hearing and strongly urge you to continue your efforts to maintain Federal nursing home standards, including reforms enacted in OBRA 87.

ASCP represents over 6,000 consultant pharmacists across the country. ASCP members provide medication distribution and consultant pharmacy services that help to manage and improve drug therapy outcomes for patients residing in long-term care settings, including nursing homes and assisted living facilities, subacute care units, psychiatric hospitals, facilities for the mentally retarded, prisons, hospices, and in the home. Because consultant pharmacists actually provide the services required by the nursing home standards pertaining to prescription drugs, ASCP is in a unique position to comment on the benefits to patient care that result from the drug regimen review (DRR) and other services required by those standards.

According to a recent GAO report, the elderly use more prescription drugs than any other age group and are more likely to be taking multiple prescription drugs,

which increases the probability of adverse drug reactions.[1] Further, the elderly are more susceptible to adverse drug reactions because of the aging process. As a result, many experts believe that some drugs are generally inappropriate for the elderly because equally effective and safer alternative drugs exist.

People aged 65 years or older account for about one third of all prescription drug use in this country and are at high risk for adverse drug effects.[2] Inappropriate drug use by the elderly can result in hospitalization or death. One study estimates that 17 percent of hospitalizations for the elderly are caused by adverse drug reactions.[3]

Federal nursing home laws and regulations, including OBRA 87 reforms, require nursing homes, as a condition of participation in the Medicare and Medicaid programs, to ensure that each resident's drug regimen is free from significant medication errors, unnecessary drugs, and inappropriately used antipsychotic drugs.[4] To accomplish these objectives, the Federal nursing home standards require the drug regimen of each resident to be reviewed at least once a month by a pharmacist. The pharmacist must report any irregularities to the attending physician and the director of nursing at the nursing facility, and the pharmacist's reports must be acted on.[5]

The implementation of these standards has resulted in substantial improvement in the pharmaceutical component of the care of nursing home residents and has produced benefits for overall patient care. For example:

- The nursing home standards require that a nursing facility ensure that residents are free from significant medication errors. Because of these standards, pharmacists conduct on-site review of the facility's drug distribution process to ensure that residents receive the drugs they are intended to receive. Further, pharmacists train facility staff in the proper administration of prescription drugs to avoid medication errors.
- A nursing home resident's drug regimen must be free from unnecessary medications under the Federal standards. The most common recommendation by pharmacists who conduct DRR in nursing homes is to discontinue a prescription drug because it is unnecessary.
- The use of antipsychotic drugs is substantially limited under the Federal standards. Prior to the enactment of the Federal nursing home standards, antipsychotic drugs often were used inappropriately to control unruly or disruptive patients by placing them in so-called "chemical restraints." As a result of interventions required by the Federal standards, the use of antipsychotics in nursing homes has declined by 27 percent.[6]

The services provided by consultant pharmacists under the Federal nursing home standards increase the quality of life for nursing home patients and yield substantial cost savings. According to a recent study, such services save over $668 million per year in reduced hospitalization, $300 million per year in decreased drug handling time for nurses, and $250 million per year in decreased prescription drug costs.[7] Federal nursing home standards for quality assurance and utilization review save Federal and State money by reducing or eliminating needless or wasteful expenditures.

For many reasons, market forces alone cannot work to ensure the protections inherent in the Federal nursing home standards. History teaches us that many States are unlikely to enact sufficient standards to assure high quality health care for nursing home residents if the Federal nursing home standards currently in place are repealed. The adequacy of future regulation of nursing homes by the States is even more doubtful in light of reduced Medicaid funding to the States. An additional challenge for the States in implementing block grants will be the quick and timely development and promulgation of adequate regulation of nursing homes. This is particularly problematic since many States have not updated their nursing home requirements in many years.

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[1] *Prescription Drugs and the Elderly*, Report by the General Accounting Office to GAO/HEHS—95—152, July 1995.

[2] S. Wilcox, D. Himmelstein, and S. Woolhandler, "Inappropriate Drug Prescribing for the Community-Dwelling Elderly," *JAMA*, Vol. 272, No. 4 (July 27, 1994).

[3] N. Col, J. Fanale, and P. Kronholm, "The Role of Medication Noncompliance and Adverse Drug Reactions in Hospitalizations of the Elderly," *Arch. of Int. Med.*, Vol. 150, No. 4 (Apr. 1990), 841–45.

[4] *See* 42 C.F.R. § 483.25.

[5] *See id.* at § 483.60.

[6] R. Shorr, "Changed in Antipsychotic Drug use in Nursing Homes during implementation of the OBRA–87 Regulations," *JAMA*, Vol. 271, No. 5 (Feb. 2, 1994).

[7] S. Kidder, Pharm D., M.P.H., "Cost-Benefit of Pharmacist-Conducted Drug Regimen Reviews," *The Consultant Pharmacist*, Sept./Oct. 1987.

The implementation of Federal nursing home standards has substantially improved the health and welfare of our nation's frail elderly. Currently, nursing home residents in all 50 states are protected from medication errors, unnecessary drugs and inappropriate use of antipsychotic medications—all of which were prevalent prior to the implementation of the OBRA 87 standards. Given the absence of market forces and the budgetary pressures faced by the States, it is unlikely that these standards and improvements will be maintained if Federal standards are repealed. To avoid a recurrence of the abuses of the 1970's and 1980's, we urge you to maintain the Federal nursing home standards.

STATEMENT OF THE NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

This statement is submitted on behalf of the National Association for the Support of Long Term Care ("NASL") regarding the quality of care in nursing homes. NASL represents the interests of companies nationwide which specialize in providing services, products, and supplies in the long-term care setting. It is the only organization at the national level which concentrates its concerns and endeavors exclusively on legislative and regulatory matters affecting the ancillary service and product supply components to long-term care.

NASL is very concerned that Congress is about to undermine two decades of nursing home reforms. Specifically, the consequences of block-granting Medicaid and capping Medicare reimbursement for both routine and ancillary services will be devastating. The combined effects of the proposed changes will be to underfund and deny care to higher acuity patients and reward facilities which underserve residents. NASL is concerned that inadequate reimbursement will force nursing homes to regress and become warehouses for the elderly, destroying their lives.

While NASL does not stand opposed to the broader reforms of Medicare and Medicaid, we urge you to reassess the Medicaid and Medicare proposals. While we strongly support the efforts at improved efficiencies, greater program flexibility and cost containment, we are concerned that too much, too fast, based on poor data and limited debate will undermine services to the older-old and disabled.

Turning our backs on the frail and vulnerable will bring only false savings at great social and economic hardship. Private sector experience shows that real savings only occur with the reduction of the aggregate burden of caring. Nursing homes can be the least costly, most effective setting for the post-acute services. In those settings, ancillary services are the keys to successful clinical outcomes.

What is proposed runs totally contrary to clinical and fiscal reality. Just as Congress exacerbated the homeless problem by misdiagnosing mental health services, it is about to replicate the error with the elderly and disabled. High end care services are threatened; community and home base programs will be a poor and more costly substitute, and the frail and vulnerable will back-up in costly multiple hospital stays.

Vote to slow the process, rethink the path to cost containment and develop a reasoned, sequential path toward reforms.

TESTIMONY OF THE AMERICAN DIETIC ASSOCIATION

The American Dietetic Association (ADA) appreciates the opportunity to share its views with the Committee regarding Medicaid reform and the quality of care in nursing homes. ADA's 66,500 members, trained in the science of nutrition, serve the public through the promotion of optimal nutrition, health and well-being. Many ADA members work with residents in nursing facilities and are concerned about the special nutritional needs of the elderly and disabled and the quality of care they receive.

The nation has committed to provide health care to its most vulnerable citizens—frail elderly and disabled individuals—through the Medicaid program. A current proposal before Congress could damage this commitment by eliminating essential nursing home standards. ADA members who work in long term facilities have seen firsthand the critical importance of these standards for maintaining the quality of life and the quality of care for the residents. Therefore, ADA urges Congress to maintain the current nursing home standards in the Medicaid program so that all nursing home residents would continue to enjoy the same standards of care.

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) enacted major reforms for long-term care facilities to ensure quality of care for residents. For several years ADA advocated on behalf of the ORBA 87 changes, applauded its passage and worked on the implementation of this legislation. Since that landmark legislation, ADA members have observed much needed progress in care received by the elderly

and the disabled in nursing homes. Moreover, an increased emphasis on nutritional standards in nursing homes has improved the overall health care of residents resulting in fewer hospitalizations, fewer complications and lower total care costs.

For example, the Research Triangle Institute (RTI) has determined that the improvement in care practices in nursing homes (as a result of OBRA 87) has led to improved resident outcomes. RTI has documented a 50 percent reduction in dehydration problems, decreases in nutrition problems and reduction in the prevalence of pressure ulcers (bed sores). RTI estimated that 30,000 fewer people had pressure ulcers in 1993 compared to the period before the new Federal nursing home standards went into effect. This results in significant cost savings as each pressure ulcer is estimated to cost $35,000 to heal. As further evidence, recently published findings of the Agency for Health Care Policy Research, calculate that proper treatment of bed sores would save over $40 million per year. Nutrition therapy is a vital component of proper bed sore treatment.

The specific OBRA 87 provisions that directly impacted the nutritional care of residents included three standards.

I. *Assessment.*—Assessment requires nursing home facilities to conduct initially and periodically a comprehensive, accurate, reproducible assessment of each resident's functional capacity. Among other things, the assessment must include a determination of nutritional status and requirements. This requirement has led to the development of a Resident Assessment Instrument (RAI) and a Minimum Data Set (MDS), which identify mandatory areas of needed attention, address nutritional status and leads to increased quality of care and increased quality of life. The use of these assessment tools has put greater emphasis on all aspects of care and a refocusing on the dignity of nursing home residents as individuals.

These tools have also put an increased emphasis on the role of nutrition and medical nutrition therapy in overall health status of residents. Medical nutrition therapy is defined as "the assessment of resident nutritional status followed by appropriate therapy, ranging from diet modification to administration of specialized therapies such as intravenous or tube feedings." It is a medically necessary and cost-effective way of treating and controlling many diseases and medical conditions including cancer, kidney disease, diabetes, surgical wounds, stroke and pressure ulcers. In addition, medical nutrition therapy helps save dollars by decreasing complications, decreasing the need for costly medications, and lessening the need for high technology treatment. Medical nutrition therapy addresses an individual's nutrient status—a key component of the body's healing process. For example, residents with pressure ulcers have increased protein and calorie needs and may require additional vitamins and minerals for the ulcers to heal.

II. *Necessary Care.*—Another provision affecting nutritional care is one which states that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care." Nursing facilities must ensure that residents maintain or improve their ability to perform the activities of daily living (e.g.; bathing, dressing, toileting, ambulation, and eating) if their clinical condition allows. This provision requires that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels and that they must receive a therapeutic diet whenever there is a nutritional problem. In addition, proper hydration is addressed as well as proper treatment and care for special services such as parenteral and enteral fluids.

III. *Dietary Standards.*—A third provision affecting the nutritional status of residents is a requirement that each facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Under this provision, menus must meet the Recommended Dietary Allowances.

Also under this provision, facilities must employ a qualified dietitian either full-time, part-time, or on a consultant basis. There has been a growing trend that facilities have been admitting sicker residents who have increased nutrition needs requiring the expertise of a dietitian. The registered dietitian is extensively trained and educated in the science of nutrition and its application to disease prevention and treatment. The dietitian integrates and applies the principles derived from the sciences of nutrition, biochemistry, physiology, food management and behavior to achieve and maintain health.

As part of an interdisciplinary treatment team, dietitians (a) educate team members in the science of nutrition; (b) complete a nutrition assessment that includes a review of the resident's blood chemistry, anthropometric measurements, medical history and diet history to determine nutrition status; and, (c) with the interdisciplinary treatment team, develop, administer and evaluate the resident's response to nutrition therapies as part of the overall care plan.

Dietetics professionals believe strongly that the current standards for long-term care facilities are kept as part of the Medicaid program so that all nursing home residents will continue to receive the highest quality of care. We urge the Committee to work to that end.

ADA is committed to ensuring that the frail elderly and disabled persons have the best quality of care. We are ready to work with the Committee to ensure that the integrity of the Medicaid program and the nursing home standards are maintained.

Thank you.

TESTIMONY OF ESTHER HOUSER

Thank you for this opportunity to present testimony in support of preserving the current Federal protections for people who live in nursing homes.

In the nearly 17 years I have been State Long-Term Care Ombudsman, I have seen life in Oklahoma nursing homes both before and after the Federal Nursing Home Reform Act was enacted by Congress in 1987.

I want to describe to you the importance of a continued strong Federal role in the protection of nursing home residents, using specific examples. State governments, including the State survey agencies (which conduct inspections), are very vulnerable to pressure from the nursing home industry to keep standards at a minimum level. The history of poor care practices and the lack of adequate care standards nationwide that resulted from these industry pressures were the impetus for the Federal reform law of 1987. The current Medicaid block grant proposal would repeal the 1987 Federal standards and would be devastating in its effects on the frail elderly who live in nursing homes.

The 1987 Federal quality standards have done much to correct these former wrongs. As early as 1981, Oklahoma Ombudsmen identified nurse aide training as a reasonable means to prevent many direct care problems in nursing homes. Oklahoma had *no* training requirement for nurse aides, although they provided 90 percent of direct patient care. The State Board of Health agreed that training was a worthy idea and we worked with State Health Department staff and others to develop a curriculum. However, because industry leadership did not want aide training, the Commissioner of Health refused to permit it to appear on the Board's agenda.

I would like to point out that literally it took an Act of Congress to get nurse aides trained in Oklahoma. I do not have faith that we could maintain even that basic a requirement without the support of a Federal mandate.

A second example of the fundamental changes Federal law brought to Oklahoma underscores even more clearly how necessary Federal leadership is in this area.

Before Federal nursing home reform took effect in 1990 many nursing homes in Oklahoma had *no nurse* on duty for up to 16 hours per day. The minimum Federal requirement was to have a licensed Practical Nurse for 8 hours per day. For up to 2 shifts per day, the residents' care could be supervised by a Medication Aide. The Medication Aide received only 16 hours of training in medication administration. Three quarters of Oklahoma nursing homes required nurse staffing waivers in 1990; but now facilities rightly have nurses around the clock, because of Federal law.

An informal poll of State Ombudsmen last week found that many states' licensure rules (which regulate non-certified facilities), provide less protection than current Federal law. Those of us whose state laws have been improved, because of Federal requirements, do not expect to keep the higher standards if Federal law is repealed.

The 1987 reforms included certain improvements that originated with innovative nursing home providers. But, without the involvement of the Federal Government, these ideas—such as abolishing the use of unneeded physical and chemical restraints—would never have become a national standard of practice. *We need national standards.* Without this Federal guidance, the majority of facilities would still be tying alert elders into their beds and chairs, preventing them from walking and toileting themselves and maintaining their dignity and health.

I talk with many senior citizens every week. In my experience, no matter how conservative their political beliefs, nursing home consumers want a strong Federal presence and strong Federal laws related to nursing home care. We know that without Federal oversight to support them, the States will not be strong enough to require appropriate or to enforce them.

The power differential between the U.S. Citizens who live in nursing homes and the providers of care is enormous. Nursing home residents need the power of Congress to protect them.

National Fire Protection Association

Washington Regional Office
1110 North Glebe Road, Suite 560, Arlington, VA 22201
Telephone (703) 516-4346 Fax (703) 516-4350

October 27, 1995

The Honorable William S. Cohen
Chairman, Special Committee on Aging
SD-G31 Dirksen Senate Office Building
United States Senate
Washington, D.C. 20510-6400

Dear Senator Cohen:

At yesterday's hearing on Nursing Home Quality Standards, you cited the need for continuation of uniform federal fire safety regulations in nursing homes. We appreciate very much your continuing support for minimum federal fire safety standards for the elderly, an age group that is among the highest at risk from fire and burn injuries in our Nation.

Unfortunately, the House passed H.R. 2425 "Medicare Preservation Act of 1995," deletes the Statutory requirement that Skilled Nursing Facilities meet the minimum uniform fire safety requirements of the Life Safety Code®, which is a national consensus safety standard maintained and updated by the National Fire Protection Association in the public interest.

In reviewing the Committee Report and H.R. 2425, we have discovered that the previous statutory reference to Skilled Nursing Facilities (Section 1819 (d)) has been changed to delete the specific reference to the Life Safety Code® which means that some 10,000 to 11,000 skilled nursing homes will no longer be under the uniform fire safety requirements of the Life Safety Code®. Instead, H.R. 2425 calls for the Secretary of HHS to establish and maintain standards to provide for "the assurance of a safe and adequate physical plant for the facility." (The language of the previous statute and the revised language of H.R. 2425 is shown on the attached.)

Compliance with the Life Safety Code® has been an eligibility requirement for skilled nursing facilities receiving Medicare and Medicaid funding for at least 20 years since the Social Security Act Amendments were passed by the Congress in the late 1960s. This step was taken by the Congress to put an end to the severe multiple fatality fires in health care facilities that were occurring all too frequently in the 1950s and 1960s. The program of universal application of the Life Safety Code® by HHS/HCFA has been an extremely successful model of federal/state/industry partnership. It is important to note that this program has been supported by the nursing home industry, the fire services and most state and local government officials.

The "Medicare Preservation Act of 1995" retains a major role of the Secretary of HHS and, indeed, provides for the Secretary to establish and maintain physical plant standards. Therefore, it is our conclusion that the reference to the Life Safety Code® should be re-inserted in the Budget Reconciliation Bill by the Conferees. This would provide for the continuity of a program that has worked extremely well to the benefit of our elderly population in skilled nursing homes.

I would be pleased to visit with you or your staff at any time to go into more detail on this matter or to answer any questions that you might have (703-516-4346).

Sincerely,

Anthony R. O'Neill
Vice President
Government Affairs

ARON:ews

Attachment

THE AMERICAN GERIATRICS SOCIETY
Washington Office: 311 MASSACHUSETTS AVENUE, NE. WASHINGTON, DC 20002 TELEPHONE: (202) 543-7446 FAX: (202) 543-5327
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LINDA HIDDEMEN BARONDESS
Executive Vice President

LYNN MORRISON
Washington Representative

October 25, 1995

The Honorable William Cohen
United States Senate
Washington, D.C. 20510

Dear Senator Cohen:

I am writing on behalf of the American Geriatrics Society (AGS) to urge you to preserve federal nursing home standards in the Medicaid program. The American Geriatrics Society is an organization of over 6,000 geriatricians -- physicians specially trained to care for frail, chronically ill older patients.

As providers of care for nursing home patients, we have witnessed dramatic improvements in the quality of nursing home care since federal standards were first enacted in 1987. Abuse and neglect were commonplace before these standards were enacted. Since then, there have been significant changes in the care delivered to nursing home patients. For example, the use of physical and chemical restraints has declined and patient outcomes have improved resulting in fewer expensive and unnecessary hospitalizations.

Repealing the federal protections and turning monitoring and enforcement activities over to the states without uniform national standards will turn back the clock on the substantial progress that has been made. While some states will choose to maintain minimum quality standards, many are likely to cut back on protections for nursing home residents, resulting in a deterioration of quality of care.

As doctors who devote much of their time to caring for residents in nursing homes, we urge you to restore these important federal quality standards. Repealing these protections will place millions of frail older persons at risk.

Sincerely,

Patricia Barry MD

Patricia Barry, M.D., M.P.H.
President

National Committee to
Preserve Social Security
and Medicare

November 28, 1995

The Honorable William S. Cohen
United States Senate
322 Senate Hart Office Building
Washington, D. C. 20510-1901

Dear Senator Cohen:

The National Committee to Preserve Social Security and Medicare has nearly 3,640 members and supporters in your state. We are shocked and alarmed by changes in nursing home law contained in the Medicaid portion of the Budget Reconciliation bill. These changes would destroy vital protections now available to nursing home residents.

Current law was established after Congress investigated widespread repeated evidence of harm resulting from substandard care in nursing homes across the country. These situations occurred under state enforcement authority with little federal oversight. Now, Congress proposes again weakening federal standards, oversight, and penalties and again giving most authority to the states.

Where federal funds are expended for care of the frailest and most dependent citizens, oversight by both state and federal governments is needed. Nursing home residents are not the usual marketplace consumers. They are afflicted with disabilities of frailty, multiple chronic illnesses and sensory deficits that make many blind, deaf, unable to speak or walk. Many have no personal advocates and most of them have no alternative options for care. They can not contend, unprotected by government standards, with an industry that answers to owners and stockholders for profits from public money.

We feel sure you will agree that quality care is not a partisan issue. Removing federal oversight of nursing home care is not necessary to balancing the federal budget. The nursing home residents deserve protection and the public deserves federal oversight of federal expenditures for care.

We urge you to work to retain current nursing home standards.

Sincerely,

Martha A. McSteen
President

2000 K Street, N.W., Suite 800 • Washington, D.C. 20006 • 202-822-9459

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November 1, 1995

The Honorable William Cohen
U. S. Senate
Washington, D.C. 20510

Dear Senator Cohen:

As one of many long-term care ombudsmen serving residents of nursing facilities, I thank you for supporting the Nursing Home Reform Act.

I understand that, on October 26, 1995, you convened a hearing on the Reform Act. I am delighted that Scott Severns, president, NCCNHR and John Willis, president, National Association of State Ombudsmen, were among the consumer advocates who appeared before your committee.

I am particularly delighted that you reiterated the belief that the Nursing Home Reform Act has been responsible for improvements in the provision of nursing home care and that "uniformity" is important. As this does not appear to be a popular opinion among your colleagues on the "hill," I applaud you for what appears to me to be a very courageous act.

I have asked my senators, Mr. Thompson and Mr. Frist, and my congressman, Mr. Duncan, to support this Act. I will continue to seek their help.

As one who, with a cadre of 60 volunteer ombudsmen, serves 6,000 residents in 55 nursing facilities and 75 residential homes for the aged in 16 East Tennessee counties of the Appalachian region, I can assure you that neither the social staff of these facilities nor the state licensing/quality assurance department will be the "ombudsman" for the resident. There must be a third-party, objective person speaking on behalf of these residents and working to assure the highest level of care and life for the residents.

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Page Two - Senator Cohen

During my 15 years as the East Tennessee long-term care ombudsman, I have seen ombudsmen in my district and across the nation protecting the rights of residents of all socio-economic classes to admission, under Medicaid, to nursing facilities; advocating for and monitoring the removal of physical and chemical restraints; prevention of "dumping" behavioral problem residents on mental health hospitals; counting and monitoring the staff-resident ratios in nursing facilities; and helping place "hard to care" patients (ventilator patients, AIDS patients, patients with behavioral problems, obese patients) in nursing facilities.

Thank you for your support! I wish you continued success in the service to your constituents in Maine and the residents of nursing facilities throughout our great nation. You serve our Senate well by serving our frail elders so well.

Sincerely,

Howard N. Hinds
District LT Ombudsman

HNH/s

Greenwood Center

384 Main Street • Sanford, ME 04073 • (207) 324-CARE (2273)

October 26, 1995

Senator William Cohen
322 Senate Hart Office Building
Washington DC 20510

Re: OBRA standards

Dear Senator Cohen,

I am among your constituents and am glad to be one of the many who support you as a Senator from Maine and spokesman for our citizens.

I am a nursing home administrator and operator. In nearly twenty years of service to the elderly of our part of Maine I have experienced innumerable changes in the manner of how we assure that those in our care are cared for optimally. Optimum care has always been our mission; I know we both share that mission.

Regulating fine, affordable care for institutionalized elderly is a difficult task. The bureaucracy tries to accomplish this, and I must commend their efforts. In a system so big as the one in which we work, it is difficult.

Providers have direct experience in knowing how to give care in the best fashion possible. I believe providers are -- and must be -- aware and attuned to current costs of health care , and they are also knowledgeable about how to deliver that service in the most reasonable way possible.

The American Health Care Association has experience and recommendations for reforms that I would like you to consider for inclusion in your focus on the future of OBRA standards. I hope that these recommendations are among those you are considering in your review of the OBRA standards.

Payment protection must not be separate from quality standards. States must be required to guarantee that payment rates allow facilities to comply with Federal standards. Payment protection and quality standards must not be separated. Payment must be able to support the quality standards.

To have onerous federal survey standards and inspections with no Federal payment protections would be devastating to this industry whose needs for service are forever increasing.

Thank you for your wisdom and fairness in regarding these matters.

Yours truly,

Richard Boisvert
Administrator

SCOTT PHARMACY, INC.
675 Main St.
Lewiston, ME 04240
207-783-1115 Fax 207-782-FAXX

October 16, 1995

Senator William Cohen
11 Lisbon St.
Lewiston, ME 04240

Dear Senator Cohen,

I am writing to you concerning the proposed changes in the nation's health insurance programs

I was pleased to see your article favoring the retention of the OBRA '87 nursing home standards. These standards, including the mandated drug regimen reviews by consultant pharmacists, have been instrumental in improving the care for the nation's elderly who reside in long term care facilities.

It is proposed that the Medicaid Drug Rebate Program be eliminated. This program has helped to control the prices of prescription medications. In Maine it has saved the Medicaid program millions of dollars. If this program is repealed, it will cost the nation hundreds of millions of dollars. This program has a minimal administrative cost to the government and saves Medicaid untold millions. Congress must resist the influence of the pharmaceutical manufacturers and retain this provision.

I am opposed to Medicaid Block Grants without some federal oversight and guidelines. If states are allowed to use these funds without proper guidelines, the elderly in long term care facilities and the poor on Medicaid will be the ones to suffer the consequences. The primary reason nursing home care has improved in the last 20 years is because of federal mandates. If this care is again left to state control, the elderly nursing home residents will again be relegated to the dark ages of care.

The health plan that is receiving much coverage is managed care. The concept of managed care sounds wonderful, but it is not the cost containment problem solver. The Maine State Employees switched to a managed care plan a few years ago. According to recent news accounts from Jo Gill, the person in charge of the MSEA plan, premiums increased about 17% last year and will increase about 12% this year. There may be cost savings in the future because people will theoretically be healthier and will be preventing problems. But for the foreseeable future, there are no savings. There has also been a significant loss of freedom of choice of provider under this plan.

Health Care Concerns, 10/16/95

I would urge Congress to not restrict freedom of choice of providers. I also ask that you more closely review the figures that are being discussed concerning possible savings under a managed care plan. On the basis of the MSEA plan, I do not believe this theoretical savings will occur.

Finally, I would ask that whatever happens to create savings, that there not be a tax cut. Any savings should be used towards balancing the budget. Tax cuts that have been proposed would favor those who need it the least. The bulk of any savings would be from programs that serve the elderly and the poor. It would truly be morally unjust to then create tax savings for those who can afford to pay the taxes. The relatively few dollars that would go to the middle class are not a realistic justification for such a cut.

I am available to discuss any of these points with you or your staff.

Thank you for your time.

Regards,

Stanley L. Tetenman
Consultant Pharmacist

MAINE VETERANS' HOME

★ Augusta ★ Bangor
★ Caribou ★ South Paris
★ Scarborough

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October 26, 1995

The Honorable William Cohen
United States Senate
322 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Cohen:

You are conducting hearings today to focus on the future of OBRA standards. I believe you are correct in conducting those hearings in order to ascertain the validity of the standards and to review their effectiveness.

In my opinion, the OBRA standards, especially the OBRA 87 standards, are necessary, but they need to be reformed into reasonable, workable and cost-effective standards. The American Health Care Association has a list of reforms that need to be included in any amendment that you are sponsoring. There must be payment protections, such as the Boren Amendment, in order to prevent wholesale payment cutbacks which States would employ. Your State, Maine, is ready to pounce on institutional care payments if and when the Boren Amendment is repealed.

Payment protection and quality standards need to be enacted together in the same legislation. This is a must. Our current onerous Federal and State survey standards and inspections cannot continue without adequate payment safeguards.

Thank you for your assistance in this matter.

Sincerely,

Roger E. Dumont
Administrator

RED/df

PRESQUE ISLE NURSING HOME

162 Academy Street • Presque Isle, Maine 04769-3198 • Telephone: 207/764-0145

November 21, 1995

Senator William Cohen
Ms. Victoria Blatter
322 Hart Senate Office Bldg.
Washington DC 20510

Dear Senator Cohen and Ms. Blatter:

Per our conversation on November 2, following are areas of documentation mandated by OBRA that significantly increase the amount of paperwork required of nurses:

PASAAR

TRIGGERS AND RAPS - PROVING THE DECISION-MAKING PROCESS IS VERY COSTLY IN TIME AND PAPERWORK.

REPEAT MDS - 21 DAY/30 DAY - "SIGNIFICANT CHANGE IN STATUS" SHOULD SUFFICE FOR REPEAT MDSs. CURRENTLY, THESE ASSESSMENTS ARE COMPLETED SIX TIMES A YEAR.

MONTHLY MED REVIEW BY AN RN - MED REVIEW CONDUCTED MONTHLY BY PHARMACIST ALREADY, WITH FINDINGS DELIVERED TO AN RN AND FOLLOWED UP BY AN RN. REDUNDANT INFORMATION

MONTHLY NURSING SUMMARIES - BETTER TIME COULD BE SPENT REVIEWING AND ADDRESSING ACTUAL CARE PLAN. REDUNDANT INFORMATION

ADL SHEETS - IN ADDITION, THE MDS MUST BE SUPPORTED BY EXTENSIVE DOCUMENTATION ON ADL (ACTIVITY OF DAILY LIVING) SHEETS.

The Interpretive Guidelines frequently create an extraordinary amount of work because of the requirement to "prove" that something was done. For example, requiring permission of the resident or responsible party before changing the mode of therapy has turned into a nightmare of paperwork. Before any change in medication, treatment, etc. can occur, the resident/responsible party must provide written documentation that he/she was informed of the change and consented to it. This seems harmless enough until one realizes how frequently changes in care are made for each resident and this is factored by the number of residents in the facility.

The Honorable William Cohen
Senate Committee on Aging
SD-G31 Dirksen Senate Office Building
Washington, D.C. 20510-6400

November 2, 1995

Dear Senator Cohen:

The American Association for Geriatric Psychiatry and the American Psychiatric Association applaud your successful efforts for retaining the OBRA 87 nursing home regulations which has significantly improved the quality of medical care delivered to nursing home patients. We would urge the conferees to address the need to promote enforcement of Section 483.25 (f) of the regulations, requiring appropriate treatment and services for residents who display "mental and psychosocial adjustment difficulties".

Between 80 - 94% of residents in long term care facilities have a treatable mental disorder. Two thirds of these are dementing illnesses, and over 60% are cases of Alzheimer's disease. However, many of the problems remain undiagnosed or inadequately treated, leaving residents to suffer unnecessarily from debilitating symptoms and associated disability. Therefore, we specifically recommend conference committee report language that would direct the Health Care Financing Administration to develop interpretive guidelines for Section 483.25 (f). These guidelines should include parameters by which nursing home inspectors can assess whether residents, who have been identified as having mental disorders or psychosocial problems, are in fact receiving appropriate mental health treatment and services. The guidelines should refer to specific areas of mental health assessment that are covered in the Minimum Data Set (such as cognitive patterns, mood and behavior patterns) and the Resident Assessment Protocols (delirium, mood state and communication).

Enclosed is proposed committee report language and some background information. If you need further information, please contact Janet Pailet at the American Association for Geriatric Psychiatry or Nicholas Meyers, at the American Psychiatric Association.

Sincerely yours,

Ira R. Katz, M.D.
President
American Association for
Geriatric Psychiatry
(301) 654-7850

Jay B. Cuder
Director of Government Relations
American Psychiatric Association

(202) 682-6164

Proposed Conference Committee Report Language:

The Conference Committee is concerned that residents of long term care facilities, over 80% of whom have treatable mental diseases, may not be receiving appropriate mental health services as required under Section 483.25(f) of the OBRA regulations. We direct the Health Care Financing Administration to develop interpretive guidelines which include parameters by which nursing home surveyors can assess whether residents, who have been identified as having mental disorders, are in fact receiving appropriate mental health treatment and services.

The American Association for Geriatric Psychiatry urges the Conference Committee to propose a measure to promote enforcement of Section 483.25(b) of the Regulations pertaining to the Nursing Home Reform Amendments to the Omnibus Budget Reconciliation Act of 1987. This Section of the Regulations requires that nursing facilities "must ensure that a resident who displays mental or psychosocial adjustment difficulties receives appropriate treatment and services to correct the assessed problem". We are concerned that older adults residing in long-term care facilities have a high prevalence of treatable mental disorders, but that many of these problems remain untreated or inadequately treated, leaving residents to suffer unnecessarily from distressing symptoms and associated disability. Therefore, we specifically recommend that the Committee direct the Health Care Financing Administration (HCFA) to develop interpretive guidelines to help surveyors of long-term care facilities determine whether, for cases in which the required assessment under Section 483.20 reveals the presence of mental disorders or psychosocial problems, residents of those facilities are receiving appropriate mental health treatment and services.

Epidemiological studies have consistently revealed that the prevalence of diagnosable mental disorders in nursing facilities is between 80 percent and 94 percent. Approximately two-thirds of these are dementing illnesses, and over 60 percent of these are cases of Alzheimer's disease. Although most dementing illnesses, including Alzheimer's disease, cannot be cured, many residents with dementia experience complications from comorbid psychiatric conditions and symptoms for which effective treatment is available. For example, psychotic symptoms such as delusions and hallucinations have been reported in approximately 25 percent to 50 percent of residents with a primary dementing illness; and clinically significant depression is seen in approximately 25 percent of the residents dementia. Behavioral disturbances have been found in two-thirds to three-fourths of residents with dementia. These problems are usually associated with subjective distress and suffering, and lead to further decline in the residents' level of function, causing disability in excess of that due to the dementia alone.

Because many of these concurrent psychiatric symptoms and disorders respond to treatment interventions, it is important to ensure that they are identified, diagnosed and properly treated. In particular, an NIH Consensus Conference Statement in 1992 emphasized the benefits of identifying and treating depression in older adults, and controlled clinical studies have consistently demonstrated that depression in nursing home residents can be effectively treated. Other treatment studies have shown alleviation of psychotic symptoms and behavioral disturbances, with associated improvement in level of function, despite the presence of incurable dementia. Therefore, when nursing home residents with Alzheimer's disease or other dementias are found to have secondary psychiatric complications and concurrent disorders, psychiatric treatment is necessary. Because such treatment is likely to be beneficial, it should be routinely available.

The current HCFA Regulations require that "the facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident * * *" including assessment of the resident's mental state and psychosocial function. The Minimum Data Set (MDS) and the Resident Assessment Protocols (RAPs) are instruments developed by HCFA that are now widely used in nursing facilities throughout the United States to perform the required assessments. These assessments are intended to promote the identification and diagnosis of treatable mental disorders.

While surveyors of long-term care facilities have guidelines to help them determine whether facilities are in compliance with the requirements for assessment, there is no mechanism to ascertain whether the many residents who are found to have mental disorders are indeed receiving appropriate treatment. The 1984 National Nursing Home Survey Pretest revealed that mental health professionals provided care for only 2 percent of all residents and that mental health services were available to less than 5 percent of residents with a known psychiatric illness. A 1986 report of the Institute of Medicine indicated that depression in nursing home residents was undertreated. However, recent studies of the impact of OBRA 87 have not shown a significant increase in the use of antidepressant medication in nursing homes. This is not surprising, since the existing HCFA Regulations and Guidelines focus more on limiting the use of medications for psychiatric disorders and do not include mechanisms to ensure nursing facilities' compliance with the requirements to provide necessary mental health treatment and services.

It is for these reasons that we believe the mental health and well-being of nursing home residents would be best served by the adoption of a measure to enforce compliance with the requirements for mental health treatment and services. We recommended that this be accomplished by directing HCFA to develop interpretive guidelines that can be used by surveyors to determine whether a nursing facility

is providing appropriate mental health treatment and services. These guidelines should refer to specific areas of mental health assessment that are covered in the MDS (such as cognitive patterns, mind and behavior patterns) and the RAPs (such as delirium, mood state, and communication). HCFA can then develop algorhythms that specify a range of acceptable treatment interventions and service options that should be offered or implemented in response to the findings documented from the assessment. When a surveyor finds that the assessment revealed a mental health problem or diagnosis, and there is no documentation of specific, acceptable mental health treatment interventions or services, or explanation in the medical record indicating the reason that mental health treatment or services were not provided, the facility and should be queried regarding the apparent lack of compliance with the requirements.

NASW
National Association of Social Workers

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December 21, 1995

The Honorable William S. Cohen
U.S. Senate
Washington, D.C. 20510-1901

Dear Senator Cohen:

On behalf of the 155,000 members of the National Association of Social Workers (NASW), I urge you to support preservation of the Nursing Home Reform Act, in its entirety, through the 1995 budget reconciliation process.

The nursing home standards of the 1987 Nursing Home Reform Act were developed with the participation of consumers, professionals, and the nursing home industry. These standards were the result of extraordinary effort, negotiation, and compromise. I find it unconscionable that a conference committee chose to tear these standards apart without even the benefit of a single hearing.

As you are aware, enactment of the federal nursing home standards followed a 1986 report by the Institute of Medicine (IOM) that documented a history of inadequate care and abuse of nursing home residents. The budget reconciliation conference report guts these standards, severely weakens survey and certification requirements, and undermines the law's enforcement provisions.

Among the standards eliminated by the conference report was a condition of the 1987 law that requires nursing facilities with more than 120 beds to employ at least one social worker to provide or assure the provision of social services to residents. The provision is a prime example of the extraordinary effort, negotiation, and compromise that characterized the development of the federal nursing home standards.

The IOM report, Improving the Quality of Care in Nursing Homes, documented the need to improve the provision of social services in nursing homes and recommended that each facility with 100 beds or more employ a full-time social worker with a bachelor's or master's degree in social work or an equivalent degree in an applied human service field approved by the State. It was through concerted negotiation among NASW, the nursing home industry, and others that a compromise was reached on the standard, restricting the requirement to nursing homes with more than 120 beds and allowing nursing homes to meet the requirement by employing an individual with a bachelor's degree in social work or an equivalent degree. The compromise also allowed nursing homes to "grandfather in" employees

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currently performing the function who did not meet the educational requirement.

NASW also opposes the removal of other essential nursing home standards, including

* The requirement that facilities provide care and services to allow each resident to attain or maintain his or her highest practical level of physical, mental, and psychosocial functioning
* The right to quality care and quality of life for each resident
* The use of federal, standardized data collection in conducting resident assessments
* Strong survey and certification requirements to provide adequate oversight of the facilities
* Resident (and family) protections against expensive private payments to nursing homes
* Standardized requirements regarding training and in-service education for workers providing nursing or nursing related services.

NASW is very appreciative of your ongoing efforts to support quality care in our nation's nursing homes. We hope we can count on your continued support to retain the critical standards contained in the Nursing Home Reform Act.

Sincerely,

Robert H. Cohen, J.D., ACSW
Executive Director

Michigan Office of the State Long Term Care Ombudsman

A Voice for Residents of Long Term Care Facilities

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1-800-833-9548

TO: Senator William Cohen
FROM: Hollis Turnham, State LTC Ombudsman
RE: **Why states should not be allowed to "waive" federal nursing home standards by using accreditation standards**
DATED: October 27, 1995

First, thank you, thank you, thank you for all the work you and your Republican and Democratic colleagues did to keep a federal presence in nursing home standards.

Second, I understand that senators Roth and Doyle may be offering an amendment to allow states to "waive" federal standards if their state regulations are stricter. This language raises two concerns.

1. All state standards, including resident rights, public and Ombudsman access, survey protocols and enforcement provisions must be stricter than federal.

2. I fear that this language would a lead to an accreditation of facilities rather than an inspection process. At least for nursing homes, the current accreditation practices are not comparable.

- Accreditation investigations are, generally, announced to the facility.
- There is little or no resident, family, or Ombudsman participation in most accreditation processes. See attached articles on hospitals not wanting the results shared with the public.
- Many current users of JCAHO are very upset that it is trying to serve too many masters. See the attached article discussing the Michigan Hospital Association's disagreements with JCAHO and role conflicts.
- JCAHO survey/inspection results are not easily available to consumers or their advocates. Charges are prohibited, difficult to get results of just one or two homes, and take a long time to get.
- Accreditation processes fall more on the line of "peer review" and "quality assurance" programs and therefore should stay separate from the licensing and enforcement responsibilities of government. Again, see blip on the conflict in roles.
- See the attached 4 articles from the Michigan Hospital Assn newsletter which outlines many of the steps JCAHO is taking to calm that industries fears about public disclosure of performance evaluations.

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

MONDAY REPORT

Vol. XXVI, Number 4

January 30, 1995

THIS WEEK

- The PHA Payment Practices Committee will meet Wednesday. Contact Steve Ehmry at the MHA for more information.
- The PHA Benefit Administration Subcommittee will meet Thursday. Contact Steve Ehmry at the MHA for more information.

Task Force on JCAHO Examines Critical Issues

Last week, the MHA Task Force on Joint Commission Accreditation met for the first time to discuss issues related to accreditation. The task force was formed at the request of the MHA Corporate Board in response to many concerns expressed by MHA members. The group's objective is to assist MHA in developing an association-wide accreditation strategy in conjunction with the American Hospital Association's national efforts.

During the initial meeting, the group reviewed the findings from an MHA survey conducted in preparation of JCAHO President Dennis O'Leary's meeting with the MHA Corporate Board last November. The task force identified additional operational concerns with JCAHO performance that were not described in the survey report. These suggested opportunities for improvement will be forwarded to AHA and JCAHO for consideration.

Finally, the group analyzed AHA's "Crisis in Confidence" statement and the preliminary response from JCAHO leadership. While noting the importance of the operational issues to be addressed by JCAHO, the task force also identified the potential conflict of an organization that acts as an accreditor, educator, consultant, and consumer advocate. The future roles and directions of the Joint Commission, as well as corporate governance issues, will be the focus of the annual JCAHO Board of Commissioners retreat, scheduled for March. The task force intends to convene again after the retreat to further develop an accreditation strategy. *(Crafton)*

1995 Day at the Capitol

'Day at the Capitol' to Feature MHA Members Influence on Community Health

The 1995 MAHA/MHA "Day at the Capitol" will be held March 15 in Lansing, and will feature more than 40 exhibits highlighting MHA members' involvement in improving the health status of their communities. A new feature this year, these exhibits will showcase to legislators who will be in attendance the importance of health providers in the well being and growth of Michigan communities. The day will also be marked by a special breakfast reception with legislators and their staffs, and a special presentation by Dr. Bob Arnot, noted physician, author, and TV commentator on health in the United States.

MHA

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REPUBLICAN GOVERNORS ASSOCIATION

NOW AMERICA'S MAJORITY

November 20, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, DC 20515

Dear Speaker Gingrich:

On behalf of the nation's Republican governors, we want to express our thanks for your efforts in reaching a strong and workable compromise on the Medicaid program within the Balanced Budget Act of 1995. The provisions in the conference agreement represent a hard-fought victory for the states, providing protections for low-income pregnant women, children, the disabled, and the elderly while maintaining state flexibility and enabling meaningful reforms. We are grateful to you for including us in this historic partnership.

Now that we have achieved this mutual victory, we want to assure you of our strong and continuing commitment to the provisions in this bill. However, any attempts to weaken states' flexibility by the addition of a federally-defined benefits package, a per-capita cap or other entitlements, a federal definition of the disabled population, or deletion of the federal cause of action language will be unacceptable to Republican governors. While we support the federal standards for nursing homes in the bill, our support is contingent on maintaining the state enforcement provisions in the conference agreement. If any of the above-mentioned changes are made to the bill, states would be faced with the worst of all possible worlds -- perpetuation of the current expensive, unwieldy, and failed Medicaid system.

There have been recent reports from the Administration that they will insist on the current program based on a per-capita capped entitlement for Medicaid recipients. Republican governors are unalterably opposed to this concept as an unfunded mandate that would limit the federal government's financial responsibility but not the states' responsibility.

310 FIRST STREET, SOUTHEAST • WASHINGTON, D.C. 20003 • (202)863-8587 • FAX (202)863-8659
Paid for by the Republican Governors Association

Speaker Gingrich. Page 2

The nation's Republican governors are committed to Medicaid reform but can only do so with maximum flexibility provided for under a block grant approach. We pledge our continued support to maintaining the strong and workable provisions in the Balanced Budget Act of 1995 as we continue to work together in partnership with Congressional leadership.

Sincerely.

1995.12-06 17:37 #320 P.02/08

AARP

Bringing lifetimes of experience and leadership to serve all generations.

December 5, 1995

The Honorable William S. Cohen
Chairman, Senate Special Committee on Aging
SD-31 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cohen:

I write to thank you for your strong leadership and commitment to preserving nursing home quality for our nation's most vulnerable older Americans. Without your efforts, the Senate would not have maintained nursing home quality protections in its reconciliation bill.

I also want to commend you for your considerable positive influence on numerous other aspects of the budget bill. You developed comprehensive anti-fraud and abuse language for the Senate bill that gets tough with unscrupulous providers and increases valuable resources for enforcement efforts. Your support for protections for low-income Medicare beneficiaries helped the Senate to take the small, but nonetheless important, step toward assuring that access to basic health care coverage for low-income older Americans will remain, even under a Medicaid block grant. In addition, your continued support for the Medicare balance billing limits has helped to protect beneficiaries from uncontrollable out-of-pocket costs. We hope these protections can be extended to new Medicare coverage options as well.

There is much yet to be done on all these issues, particularly in light of some of the provisions in the House-Senate Conference Report. We look forward to working with you in the coming weeks to strengthen protections in the bill as it emerges from negotiations with the Administration.

Your strong roles as Chairman of the Senate Special Committee on Aging and advocate on behalf of older Americans have given us confidence that retired persons throughout the nation can rely upon a leader who will champion their interests and concerns. We look forward to continuing to work closely with you and your excellent staff to make further improvements in the budget proposal to protect and enhance the lives of older Americans.

Thank you again for your efforts.

Sincerely,

Horace B. Deets

American Association of Retired Persons 601 E Street, N.W., Washington, D.C. 20049 (202) 434-2277
Eugene I. Lehrmann *President* Horace B. Deets *Executive Director*

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AROOSTOOK MEDICAL CENTER,
November 22, 1995.

Hon. WILLIAM COHEN,
322 Hart Senate Office Building, Washington, DC

DEAR SENATOR COHEN: Thank you for your efforts to maintain the health of this country's most vulnerable, frail and elderly citizens through implementation of the Medicaid nursing home standards. Please continue this commitment by ensuring the elimination of these standards is not a part of the Medicaid changes in the budget reconciliation bill.

As a nutrition professional working in long-term care, I know the critical importance of Federal nursing home standards on maintaining quality of life and quality care. Medicaid nursing home standards establishing minimal nutrition assessment and staff levels are key to the effective treatment of pressure ulcers (bed sores), strokes, diabetes and renal disease. According to recently published findings of the Agency for Health Care Policy Research, proper treatment of pressure ulcers (bed sores) would save over $40 million per year. Nutrition therapy is a vital component of proper pressure ulcers treatment. We should be considering increasing (not decreasing) standards to achieve greater cost savings in the health care system.

During the reconciliation bill conference, please maintain this commitment by including the current nursing home standards in the conference bill. We appreciate all your support for high quality nursing home standards and medical nutrition therapy by dietitians.

Cordially yours,

LAURIE BROWN-ELIAN.
JULIE LLOYD-WALSH.
DIMEREZE CLARK.

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ISBN 0-16-052450-4